Name and Address

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Demographic and Contact

Date of Birth: _____ Gender: ☐Male ☐ Female SSN: _____

Marital Status: ☐Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Method of Contact: ☐Cellular ☐ Home ☐ Email ☐ Other

Home Phone: (_____) _____ Cellular Phone: (_____) _____

Email Address: _____ Preferred Language: _____

Emergency Contact

Name: _____ Relationship to Patient: _____

Primary Phone: (_____) _____ Alternate Phone: (_____) _____

Additional Information

Race: ☐ Black/African American ☐Native Hawaiian/Pacific Islander ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐Other

Ethnicity: ☐Hispanic/Latino ☐ **Non**-Hispanic/Latino

Employment Information

Employer: _____ Work Phone: (_____) _____

Employer Address: _____

City: _____ State: _____ Zip Code: _____

Responsible Party (if not patient)

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State _____ Zip Code: _____

Primary Insurance

Insurance Company _____ Telephone Number: (_____) _____

Name of Policy Holder _____

Policy Holder DOB _____ Policy Holder SSN _____

Policy/Subscriber ID Number: _____ Group Number: _____

Secondary Insurance (if applicable)

Insurance Company: _____ Telephone Number: (_____) _____

Name of Policy Holder: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Policy/Subscriber ID Number: _____ Group Number: _____

How Did You Hear About Us?

☐ Insurance Carrier ☐ Another Patient ☐ TV ☐ Radio ☐ Flyer ☐ Pediatric Dentist -_____

☐ Hospital _____ ☐ Another Healthcare Provider (please provide name): _____

☐Other (please indicate source): _____