PATIENT INFORMATION

Today's Date _____

Last Name _____First Name _____ MI _____

Address:_____ City_____

State _____ Zip_____ Telephone: Home: (_____)_____

Work: (_____)_____ Cell: (_____)_____

E-mail:_____ Pharmacy Name/Location _____

Employer _____ Occupation _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____Relationship:_____SS #_____

Address:_____

City_____ State _____ Zip_____

Emergency Contact:

Name:_____Relationship_____Phone#(_____)_____

Reason for today's visit?_____

How did you hear about us? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co Address _____

Insurance Phone # _____

Employer _____ Group #_____

Insured Name: _____ID# or SS#_____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE:	DATE: