B PATIENT'S NAME - Please print

Mr. / Mrs. / Miss — LAST / FIRST / MIDDLE INITIAL		Date	Chart No.
Patient's Address	City-State-Zip		
Home Phone	Work Phone	Patient's Soc. Sec. No.	Date of Birth
Patient's Employer	Employer Address	City	
Referred by Dr.	Regular Family Dentist If Different Than Referring Dr.		

A PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Last Name	First Name & Middle Initial	Date of Birth
Street Address	City-State-Zip	
Home Phone	Soc. Sec. No.	Occupation
Employer	Employer's Address	
City-State-Zip	Business Phone	

FILL OUT ONLY IF YOU HAVE DENTAL INSURANCE

C PRIMARY DENTAL INSURANCE INFORMATION

Employee's name who has insurance coverage		
Soc. Sec. No.	Date of Birth	
Employer's Name		
Address		
Name of Insurance Company		
Address		
City-State-Zip		
Is this employee: ☐ Hourly ☐ Salaried ☐ Other		
What percentage will this Insurance Company cover? %		
Group No.	Service Code	Other ID No.
How is employee related to patient? ☐ Subscriber ☐ Spouse ☐ Dependent		

D FILL OUT ONLY IF YOU HAVE SECONDARY INSURANCE

Employee's name who has insurance coverage		
Soc. Sec. No.	Date of Birth	
Employer's Name		
Address		
Name of Insurance Company		
Address		
City-State-Zip		
Is this employee: ☐ Hourly ☐ Salaried ☐ Other		
What percentage will this Insurance Company cover? %		
Group No.	Service Code	Other ID No.
How is employee related to patient? ☐ Subscriber ☐ Spouse ☐ Dependent		