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PATIENT'S FULL NAME: _____ DATE OF BIRTH: _____

PATIENT'S ADDRESS: _____ CITY _____ ST _____ ZIP _____

PATIENT'S HOME PHONE: _____ /CELL PHONE: _____ /WORK PHONE: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____ PATIENT'S AGE: _____

PATIENT'S MARITAL STATUS (PLEASE CIRCLE) SINGLE MARRIED DIVORCED WIDOWED

PERSON RESPONSIBLE FOR THIS ACCOUNT (IF OTHER THAN PATIENT) _____

PERSON RESPONSIBLE SOCIAL SECURITY NUMBER: _____

PATIENT/PARENT EMPLOYER: _____

SPOUSE'S NAME: _____ EMPLOYER: _____ WORK PHONE: _____

DO YOU HAVE DENTAL INSURANCE? YES OR NO DO YOU HAVE MEDICAL INSURANCE? YES OR NO

IF YES, COMPLETE THE INSURANCE INFORMATION LISTED BELOW:

| | |
|---|----------------------------------|
| CARDHOLDER'S NAME (IF OTHER THAN PATIENT) _____ | |
| SOCIAL SECURITY NO. _____ | DATE OF BIRTH: _____ |
| CARDHOLDER'S EMPLOYER _____ | ADDRESS: _____ |
| CITY: _____ | ST: _____ ZIP: _____ |
| INSURANCE COMPANY NAME: _____ | GROUP#: _____ |
| ADDRESS: _____ | CITY: _____ ST: _____ ZIP: _____ |

PHARMACY NAME & PHONE#: _____

REFERRED BY: _____

NAME OF DENTIST: _____

NAME OF PHYSICIAN: _____

EMERGENCY CONTACT: _____

HOME PHONE (OTHER THAN PATIENT'S): _____ WORK #: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

IT IS OKAY TO SPEAK WITH _____ REGARDING MY TREATMENT AND ACCOUNT

I _____, HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

SIGNATURE _____ DATE _____ OK TO TEXT _____