



"Your One Stop Dental Shop"

Who may we thank for referring you? _____
How did you hear about us? _____
Do you currently have a dentist? _____
Email: _____

Patient Information

Name: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____ Ext: _____
SSN: _____

How would you like us to contact you? Home Cell Work Email
GYN One: Minor Single Married Divorced Separated
If patient is a minor, are parents: Married Divorced Separated Other: _____
Emergency contact: _____ Home: _____ Cell: _____
Work: _____ Ext.: _____

Responsible Party

If other than patient

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____ Ext: _____
SSN: _____ Birth Date: _____

Dental Benefits

Policy Holder: _____ SSSS Relationship to patient: _____
Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ Birth Date: _____
Employer: _____ Employer's Phone: _____
Benefits Company: _____ Phone _____
Address: _____ City: _____ State: _____ Zip: _____
Group Number: _____ ID Number: _____

Secondary Dental Benefits

Policy Holder: _____ SSN: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Employer's Phone: _____
Benefits Company: _____ Phone _____
Address: _____ City: _____ State: _____ Zip: _____
Group Number: _____ ID Number: _____

X _____ Date: _____
Signature of Patient or Parent/Guardian (if minor)