Updated_____

Patient Information

Name as it appears on your Insurance: Last, First, MI	Date of Birth:	Sex:	Social Security #:
Name Preferred to be called:	Home phone number:	Cell phone number:	
Home/ Billing Address:	Email:		
Marital Status: Single / Married / Widowed/ Divorced	Employer:	Work phone number:	
Spouse's Name and phone number:	Other family members that are patients here:	Who can we thank for referring you?	
Emergency Contact Name:	Relationship to you:	Emergency Contact Phone Number:	

Insurance Information

Dental Insurance Company Name:	Dental Insurance Address:		
Dental Provider Toll Free Phone #:	Subscriber's ID #:	Subscriber's Social Security #:	
Subscriber's Name:	Subscriber's DOB:	Group Name:	Group #:

Our office calls to confirm appointments as a courtesy to our patients. Our automated system sends reminders for upcoming appointments via email, text, and phone. You may opt out if you prefer not to receive these reminders.

I authorize that my records, photographs, and x-rays may be used for diagnostic or educational purposes. I certify that I have provided accurate information and have read the contents of this form and realize the risks and limitations involved.

Patient (or Guardian if under 18) Signature:	Date: