JUST FOR GRINS
family dentistry

Patient Information:

Patient's Name:____
Last First Middle Preference

Birthdate:________________ Male / Female:________________ Marital Status:____________________

Social Security #:______________________ Driver's License#:______________________ State:__________

Address: ____
Street Apt. # City State Zip

Cell: ________________________ Home: ________________________ Work: ________________________ ext__________

Email Address: ____ Employer: ____

Spouse's Name:______________________________ Birthdate: ___________ Social Security #:______________________

Spouse's Employer:_____________________________________ Spouse's Work Ph:____________________________

Is a member of your family a patient here:_______________ Name:____

How did you hear about us? : ____

Person to contact in case of an emergency:______________________________________ Phone: _______________________

Responsible Party Information:

Self:____________________ Other: ____
Last First Middle

If "Other," please complete: Relationship to Patient: ____

Birthdate: ________________ Social Security #:________________________ Driver's License# :__________________

Address: ____
Street Apt. # City State Zip

Home Ph:___________________________________ Work Ph:__________________________________ ext_________

Insurance Information:

Name of insured: _______________________________ Relationship to Patient: _____________________________________

Birthdate: ______________ Social Security #: ___________________ Employer: ___________________________________

Insurance Co: _________________ Group #: __________________ Phone: ____

Patient's Signature:____ Date:_________________

Parent/Guardian signature if patient is a minor:____