DATE_____ **CONFIDENTIAL RESPONSIBLE PARTY INFORMATION** A B C

Father/Mother/Self: _____ Marital Status_____
Last First Middle

Residence _____ Own___ Rent ____
Street City State Zip

How long at this address: ____Previous Address_____
(if less than 3 yrs.) Street City State Zip

Phone: Home:_____Cell: _____ Work: _____

Social Security #_____ Birthdate: _____ Relationship to Patient: _____

E-Mail Address: _____

Employer: _____ No. Years Employed _____

Father/Mother:_____ Relationship to Patient: _____
Last First Middle

Residence _____
(if different than above) Street City State Zip

Phone: Home: _____Cell: _____ Work: _____

Social Security # _____ Birthdate: _____ Employer: _____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ ID/Soc.Sec.# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____

Insurance Co Phone _____ Policy Holder's Employer: _____

Do you have dual coverage? _____ Yes _____ No If yes:

Policy Holder's Name _____ ID/Soc.Sec.# _____

Insurance Company _____ Group # _____

Insurance Co. Address _____

Insurance Co Phone _____ Policy Holder's Employer: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____

Complete Address: _____

Phone: _____ Relationship: _____

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) _____

Updates (date & initial) _____