DENTAL
SPECIALISTS, PC

Patient Last Name:____________________ First:________________________ Middle:__________________ Age_______

Patient Nickname:____________________ Male or Female:______________

Street Address:______________________________________ Apt. #_________

City:____ State:__________________________Zip:______________________

Home Phone:____________________ School Name:________________________________Birth Date:_______________

Cell Phone:______________________Email Address:________________________________

Is it okay to contact you by text? __Yes __No Is it okay to contact you by Email? __Yes __No

Name(s) and age(s) of siblings:

____

RESPONSIBLE PARTY INFORMATION

Last Name:____________________________________ First:__________________ _________Middle:__________________

Street Address:___________________________________ ______Apt#:_______ Home Phone #______________________

City:____ State:_____________________________ Zip:___________________

Social Security #____________________________________ __________________Birth Date:______/______/_______

Relationship To Patient:___________________________________Drivers License#:_________________________

Employer Name:____ Work Phone #_________________X:_________

Occupation:____ No. of Years Employed_______________

Spouse's Last Name:_______________________________ First:_________________ ______Middle:__________________

Relationship To Patient:__________________________________ Drivers License#:__________________________

Social Security #____ Birthdate:_____/_____/______

Work Phone#___________________x_________ Employer Name:_________________

Occupation:____ No. of Years Employed_______________

Whom May We Thank For Referring You To Our Office?____

INSURANCE INFORMATION

Insured's Name: (Dental)______________________________________ Insured's Soc. Sec. #_______________________

Insurance Co. Name:____ Group/Plan #_______________________

Insurance Co. Address:____

Do you have Medical Coverage? ___Yes ___No

Insured's Name:____ Insured's Soc. Sec. #______________________

Medical Insurance Co. Name:____________________________________ Group/Plan#__________________________

Insurance Co. Address:____

Insured's Employer:____

I, by signing below, certify all of this information to be true:

Parent (Guardian) Signature:____Date________________________

Printed Name:____