ADULT INFORMATION FORM
OR RESPONSIBLE PARTY

Patient's Name:_____ Nickname:_____

D.O.B.:_____ Social Security #:_____

Home Phone:_____ Cell Phone:_____

E-mail:_____
(We don't give or sell this to any other people)

Address:_____ C/S/Zip:_____

Are you: Married☐ Separated☐ Divorced☐ Single☐

Employer:_____ How Long:_____ Occupation:_____

Work Phone:_____ May we contact you or leave a message?Message

Are you the policy holder for insurance? YES◯ NO◯

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

***UNLESS OTHERWISE SPECIFIED, YOU ARE CONSIDERED RESPONSIBLE FOR YOUR ACCOUNT.**

OTHER RESPONSIBLE PARTY INFORMATION and/or EMERGENCY CONTACT

Name:_____ Social Security #:_____

D.O.B.:_____ Relationship to Patient:_____

Address (if different):_____ C/S/Zip:_____

Home Phone:_____ Cell Phone:_____

Employer:_____ How Long:_____ Occupation:_____

Work Phone:_____ May we contact you or leave a message?_____

Are they the policy holder for insurance? YES☐ NO☐

DENTAL INSURANCE INFORMATION

Member ID:_____ Group #_____

Insurance Company:_____ Insurance Phone #:_____

Insurance Company Address with C/S/Z:_____

Do you have dual coverage? YES____ NO____ **If yes, Please fill in below.**

Member ID:_____ Group #_____

Insurance Company:_____ Insurance Phone #:_____

Insurance Company Address with C/S/Z:_____