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Patient Adult Information

PATIENT

Date _____ Patient's First and Last name _____ Middle initial _____

Title__ Mr. __ Mrs. __ Miss __ Dr.__ Other I prefer to be called _____

Birth date _____ What sex were you assigned on your birth certificate? __ Male __ Female

What is your current gender identification? __ Male __ Female __ Other What are your preferred pronouns? _____

Marital Status __ Single __ Married __ Separated __ Divorced __ Widowed

Home address _____ City, State, Zip code_____

Cell phone _____ Home phone _____ Work phone _____

E-mail address(es) _____

Occupation _____ Employer_____

Emergency Contact

Spouse or closest relative's name(s) _____ Relationship to patient _____

Title __ Mr. __ Mrs. __ Miss __ Dr.

Address (if different than patient address) _____

Cell phone _____ Home phone _____ Work phone _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birthdate _____

Social Security # _____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ Yes __ No __ Don't know

Secondary policy holder's full name _____ Birthdate _____

Social Security #_____ Relationship to patient _____

Address and phone (if not listed above) _____

Employer _____ Address _____

Insurance company _____ Group # _____ ID # _____

Does this policy have orthodontic benefits? __ Yes __ No __ Don't know