Date_____ **Age**_____

Confidential Responsible Party Information
Please fill in completely.

Patient's Name_____

Address_____
Street City State Zip

Birthdate_____ Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

If patient is a minor, give parent's or guardian's name_____

(Custodial Parent)

Responsible Party_____ Marital Status_____

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____
Street City State Zip

How long at this address_____ Social Security #_____ Birthdate_____

Previous Address (if less than 3 yrs.)_____
Street City State Zip

Relationship to Patient_____ Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Employer_____ Occupation_____ No. Years Employed_____

(Biological Parent)

Other Parents Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Cell Phone_____ Email_____

Dental Insurance Information

Policy Holder's Name_____ and Soc. Sec.#_____

Insurance Company_____ Group #: _____ Union Local No_____

Insurance Co Address_____ and Phone #_____

Policy Holder's Employer_____ ID#:_____

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

Policy Holder's Name_____ and Soc. Sec.#_____

Insurance Company_____ Group #: _____ Union Local No_____

Insurance Co Address_____ and Phone #_____

Policy Holder's Employer_____ ID#: _____

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 (Parents signature if minor)_____

Updates (date& initial)_____