PATIENT INFORMATION

(Please PRINT LEGIBLY, in black or blue ink)

<table>
<tr><td colspan="2">Patient's Last Name</td><td>Date</td></tr>
<tr><td colspan="2">Legal First Name</td><td>Middle Initial</td></tr>
<tr><td colspan="3">What would you prefer to be called?</td></tr>
<tr><td colspan="3">Marital Status: Married Single Child Other</td></tr>
<tr><td colspan="3">Date of Birth Sex: Male Female</td></tr>
<tr><td colspan="3">Social Security Number</td></tr>
<tr><td colspan="3">Home Address</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>City</td><td>State</td><td>Zip</td></tr>
<tr><td colspan="3">E-Mail Address</td></tr>
<tr><td>Home Phone
( )</td><td colspan="2">Cell Phone
( )</td></tr>
<tr><td colspan="3">Employer/Occupation</td></tr>
<tr><td>Work Phone
( )</td><td colspan="2">Fax
( )</td></tr>
<tr><td colspan="3">Where do you prefer to be contacted? (Please offer at least two points of contact and number in order of preference.)
____Home ____Work ____Cell ____E-mail ____Fax
May we text? Y / N</td></tr>
<tr><td colspan="3">Whom may we thank for referring you here?</td></tr>
<tr><td colspan="3">Who is your general dentist?</td></tr>
<tr><td colspan="3">What is his/her phone number or office location?</td></tr>
<tr><td colspan="3">Who is responsible for payment on this account? (Do not list insurance.)</td></tr>
</table>

Please continue on reverse side.

EMERGENCY CONTACT

Last Name	First Name
Relationship to Patient	
Phone Number	

PRIMARY DENTAL INSURANCE

***Each box must be filled out completely to ensure your claim is considered**

Name of Policyholder*	
How are you related to policyholder?*	Self Spouse Dependent Other
Dental Insurance Company Name*	*(if we need medical, we will inform you)*
Policyholder's Employer*	*(if no employer, note as individual or retired)*
Group Number*	Policyholder's Date of Birth*
Policyholder's ID or Social Security Number*	

SECONDARY DENTAL INSURANCE

***Each box must be filled out completely to ensure your claim is considered**

Name of Policyholder*	
How are you related to policyholder?*	Self Spouse Dependent Other
Dental Insurance Company Name*	*(if we need medical, we will inform you)*
Policyholder's Employer*	*(if no employer, note as individual or retired)*
Group Number*	Policyholder's Date of Birth*
Policyholder's ID or Social Security Number*	

PREFERRED PHARMACY

Pharmacy Name:	
Address/City	Phone Number