FINANCIAL INFORMATION

PATIENT

PATIENT LAST NAME	FIRST	MIDDLE		TODAY'S DATE
BIRTH DATE MM/DD/YR	SOCIAL SECURITY NUMBER			MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP
HOME PHONE ☐ NONE	CELL PHONE			☐ YES, PERMISSION TO LEAVE MESSAGES ON PHONE
MAILING ADDRESS		CITY	STATE	ZIP CODE
HOME ADDRESS ☐SAME	APT.	CITY	STATE	ZIP CODE
EMAIL ADDRESS:				
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS		BUS. PHONE	OCCUPATION
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE ( )	ADDRESS	
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? HOW DID YOU HEAR ABOUT US?				RELATIONSHIP

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE
BOTH PARENTS NAMES			
PARENTS MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa		

FINANCIAL RESPONSIBILITY **IF SELF, CHECK HERE AND SKIP TO NEXT SECTION ☐**

PERSON RESPONSIBLE LAST NAME	FIRST	MIDDLE		RELATIONSHIP
PHONE	SOCIAL SECURITY NUMBER		DRIVER'S LICENSE NUMBER	STATE
HOME ADDRESS ☐SAME AS ABOVE	CITY		STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION	

PRIMARY DENTAL INSURANCE ☐NONE ☐PA, MEDICAID, WELFARE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	