Welcome to Healthy Smiles Dental!

Patient Information

O Mr. O Mrs. O Miss O Dr.
Name _____
Address _____
City/State/Zip _____
How long at current address? _____
Home Phone _____
Cell Phone _____
Email _____
Birth Date _____ Age _____ O Male
SS# _____ O Female
O Single O Married O Widowed
O Separated O Divorced O Dependent

Responsible Party
IF OTHER THAN PATIENT

Relationship to patient _____
Name _____
Address _____
City/State/Zip _____
How long at current address? _____
Phone _____
Birth Date_____ Age _____ O Male
SS# _____ O Female
O Single O Married O Widowed
O Separated O Divorced

Employment Information

Employer _____
Work Phone _____
Occupation _____
How Long at Current Job? _____

Insurance

Insurance Company _____
Address _____
City/State/Zip _____
Phone _____

Policy Holder's Employer _____
Policy Holder's Name _____
Relationship to Patient _____
Policy Holder's Birth Date _____

Policy Holder's SS# _____
Membership # _____
Group Number _____

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

Name of nearest relative not living with you _____
Phone # _____

Family Physician _____

PLEASE LIST OTHER HEALTH CARE PRACTITIONERS SEEN IN THE PAST 9 MONTHS

PRACTITIONER	SPECIALTY	APPROXIMATE DATE OF SEEN
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Patient, Parent, or Guardian ____ _____ Date _____