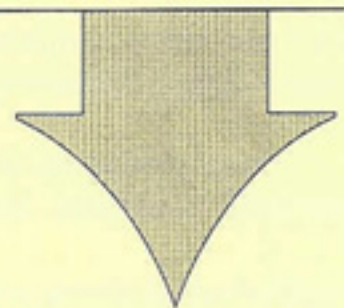
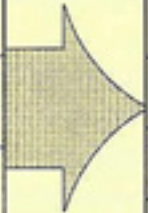


PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1			
DATE			
LAST NAME		FIRST	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
CELL		EMAIL	
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NO.			

2	
DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NO.	
INSURED'S SOCIAL SECURITY NO.	



4			
ACCOUNT INFORMATION			
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME			
RELATIONSHIP TO PATIENT		SOCIAL SECURITY NO.	
ADDRESS			
CITY		STATE	ZIP
PHONE NO.			
YOU			
NAME			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS		CITY	
PHONE NO.		FAX NO.	
YOUR SPOUSE			
NAME			
OCCUPATION			
EMPLOYER'S NAME			
ADDRESS		CITY	
PHONE NO.		FAX NO.	

3	
GETTING TO KNOW YOU	
IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?	
NAME:	RELATIONSHIP:
YOU WERE REFERRED TO US BY	
YOUR FORMER ADDRESS	
CITY	STATE ZIP
PERSON TO CONTACT FOR EMERGENCY	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	
PHONE NUMBER	
ADDRESS	
CITY	STATE ZIP

