FIRST VISIT PAYMENT:
Cash or Check
MasterCard/Visa
American Express

Mr.
Mrs.
Miss

PATIENT'S HISTORY AND INFORMATION

(Confidential information for data files.)

PLEASE USE CAPITAL LETTERS — SPACE BETWEEN WORDS

PATIENT'S LAST NAME ____________ FIRST NAME ____________ MIDDLE INITIAL ___

STREET - APT. NO. ____________
CITY - STATE ____________
ZIP CODE ____________
HOME PHONE ____ ____ ____
DATE OF BIRTH ____ ____ ____ SEX - M/F ___

SOCIAL SECURITY NO. ____ ____ ____ TAX D/L # ____________
EMPLOYED BY ____________
STREET - SUITE NO. ____________
CITY - STATE ____________
ZIP CODE ____________
BUSINESS PHONE ____ ____ ____ EXT. ______
REFERRED BY ____________

NAME OF PHYSICIAN ____________ CITY ____________

SPOUSE INFORMATION OR PERSON FINANCIALLY RESPONSIBLE IF MINOR:

LAST NAME ____________ FIRST NAME ____________ MIDDLE INITIAL ___

STREET - APT. NO. ____________
CITY - STATE ____________
ZIP CODE ____________
HOME PHONE ____ ____ ____
DATE OF BIRTH ____ ____ ____ SEX - M/F ___

SOCIAL SECURITY NO. ____ ____ ____
EMPLOYED BY ____________
STREET - SUITE NO. ____________
CITY - STATE ____________
ZIP CODE ____________
BUSINESS PHONE ____ ____ ____ EXT. ______

INSURANCE INFORMATION
PATIENT'S DENTAL INSURANCE - CARRIER'S NAME ____________
STREET - SUITE NO. ____________
CITY - STATE ____________
ZIP CODE ____________
GROUP NO. ____________

ADDITIONAL DENTAL INSURANCE - CARRIER'S NAME ____________
STREET - SUITE NO. ____________
CITY - STATE ____________
ZIP CODE ____________
GROUP NO. ____________

PLEASE ANSWER MEDICAL QUESTIONS ON BACK

FOR OFFICE USE ONLY: PATIENT ID ________ RECALL MONTH ______ CONTACT ________

PERSON FINANCIALLY RESPONSIBLE ____________ CW ____________

INSURANCE ID ____________ SUBSCRIBER ____________

INSURANCE ID ____________ SUBSCRIBER ____________