



Today's Date: \_\_\_\_\_

Please update the following information for our records and return completed form to the front desk.

Patient's Full Name: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_ Patient's Preferred Name: \_\_\_\_\_

Patient's Address: \_\_\_\_\_

Street Name/House Number/Apt Number

City

State

Zip

Mom's Cell: \_\_\_\_\_ Dad's Cell: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Best # \_\_\_\_\_

(land line)

(to be reached during normal business hours)

E-Mail Address: \_\_\_\_\_

**Primary Dental Insurance Information**

Cardholder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

ID or SSN: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**Secondary Dental Insurance Information**

Cardholder Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Employer: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

ID or SSN: \_\_\_\_\_ Telephone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Any Health Changes?: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, explain: \_\_\_\_\_

Any Allergies or Drug sensitivity? \_\_\_\_\_

Name of your General Dentist and Date of Last Cleaning:

Dentist: \_\_\_\_\_ Last Cleaning: \_\_\_\_\_

(NOT Orthodontist)

What school does patient attend? \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_