Healthy Smiles Dental Office

(Patient) LAST NAME ___________________ FIRST _______________ Middle Initial__________

STREET ADDRESS______________________________________ APT # ___________________

CITY _____________________________ STATE ___________ ZIP CODE___________________

EMAIL ________________________ @_____________________. _____________________

HOME PHONE _________________ WORK PHONE ______________ CELL PHONE ______________

GENDER: MALE / FEMALE How would you like us to confirm your appointments?_______________

DATE OF BIRTH ________________________ AGE _______________ SSN #_________________

EMPLOYER ___________________________ OCCUPATION_____________________________

EMPLOYER'S ADDRESS ____________________________STATE _________ ZIPCODE__________

EMERGENCY CONTACT ___________________ RELATIONSHIP___________ PHONE____________

COMPLETE THIS SECTION IF PATIENT IS A MINOR

NAME OF LEGAL GUARDIAN _____________________________ RELATIONSHIP _________________

STREET ADDRESS ______________________________ CITY __________ STATE ______________

ZIP CODE _________ HOME PHONE _________________ WORK PHONE ______________________

CELL PHONE ________________ EMPLOYER ____

EMPLOYER'S ADDRESS ____________________________________ STATE _____ ZIPCODE ________

HOW DID YOU HEAR ABOUT US? ____

INSURANCE INFO: If you are the policy holder, please fill-in "self" and skip last two lines.

INSURANCE ___________________________ POLICY HOLDER _____________________________

POLICY HOLDER DOB ___/___/________ POLICY HOLDER EMPLOYER ______________________

POLICY HOLDER ID# OR SSN# ____________________ POLICY HOLDER PHONE _____________