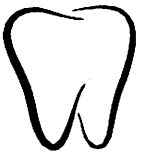

DENTAL TODAY

Full Legal Name: _____ **Nickname:** _____
First *MI* *Last*

Male □ **Female** □ **Date of Birth:** _____ **Social Security#:** _____
(required for all patients 18yrs+)

Home#: _____ **Work#:** _____ **Cell#:** _____

Address: _____

Email Address: _____

Emergency Contact Name: _____ **Phone #:** _____

For Patients Under 18:

Parent/Guardian Name: _____ **Phone#:** _____ Social Security # _____

Address(If different from above): _____ Date of Birth _____

Do you have Dental Insurance? YES NO

Dental Insurance Co. _____ Group# _____ ID#/SS# _____

Subscriber Name _____ Subscriber Date of Birth _____ Employer _____

Additional (Secondary) Insurance

Dental Insurance Co. _____ Group# _____ ID#/SS# _____

Subscriber Name _____ Subscriber Date of Birth _____ Employer _____

I understand that I am responsible for all costs of dental treatment, regardless of any insurance, and/or financial situations.

Signature of Responsible Party: _____ Date _____

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