



Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: ___/___/___ Minor (under 18 yrs) Y N

SS#: _____ Driver's License # _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Where would you like to receive confirmation communications? (please circle) Cell Phone Email Home Phone

Person to contact in case of an emergency: _____ Phone: _____

Relationship to Patient: _____

How did you hear about us? Phone Book: Santa Fe, Los Alamos , or Espanola? Internet search Website Sign Referral
If by referral, whom may we thank for referring you? _____

Please list all others involved in your healthcare and/or financial decisions. To protect your privacy, please indicate "Y" for Yes IF we may we discuss your dental treatment, appointments, and related costs with this person:

Name _____	Relationship to you: _____	may we discuss Treatment? Y N
Name _____	Relationship to you: _____	may we discuss Treatment? Y N
Name _____	Relationship to you: _____	may we discuss Treatment? Y N

Responsible Party / Legal Guardian Information (if someone other than the patient)

Name of person financially responsible for this account: _____

SS#: _____ Date of Birth: ___/___/___

Relationship to Patient: _____ Has this person been a patient at our office? Y N

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of Employer: _____ Employer Address: _____

Insurance to be Billed

Insurance Company: _____ Through an Employer? Or Individual Plan? (please circle)

Employer & Address (if through employer): _____

Subscriber: _____ Effective Date of Insurance: _____

Subscriber SS#: _____ Subscriber Date of Birth: ___/___/___

Insurance Group # _____ Subscriber ID# _____ Patient ID # _____

X

Signature of Patient / Parent or Guardian (if a minor)

Date