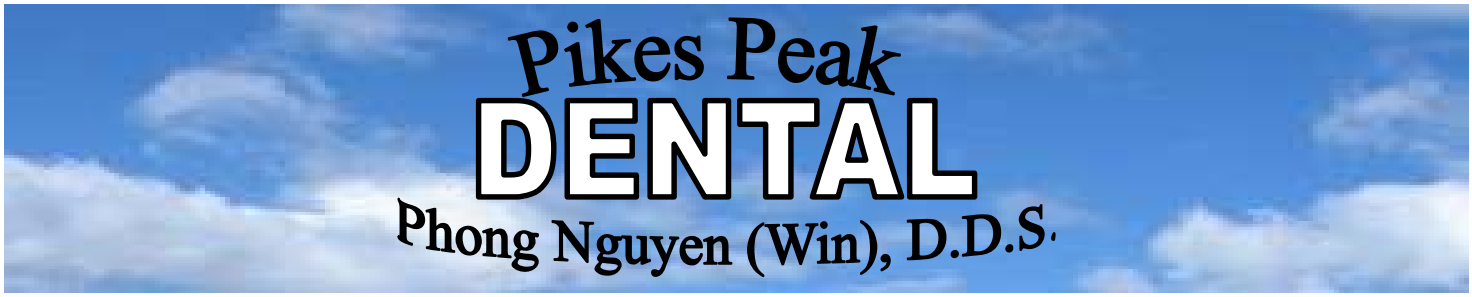

PATIENT INFORMATION

DATE: _____

Patient name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip code: _____

Home # _____ Work # _____ Alt. # _____

Social Security # _____

Circle all that apply: Male Female Single Married Minor

Responsible Party Name: (if different from above) _____

Address: (if different from above) _____

City: _____ State: _____ Zip code: _____

Home # _____ Work # _____ Alt # _____

Emergency Contact: Name: _____ Phone #: _____

Insurance Information:

Primary Insured

Name : _____ Social Security #_____
Address: _____ Date of Birth: _____
City: _____ State _____ Employer: _____
Zip Code: _____ Insurance Company: _____
Relationship to Patient: _____

Secondary Insured

Name : _____ Social Security #_____
Address: _____ Date of Birth: _____
City: _____ State _____ Employer: _____
Zip Code: _____ Insurance Company: _____
Relationship to Patient: _____

Whom may we thank for referring you to our office? _____

Is there anything you would like to change about your teeth or smile? _____
_____
_____

5430 Powers Center Point, Suite 110 Colorado Springs, CO 80920
719-590-1616 719-590-1618 FAX