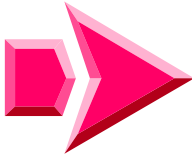
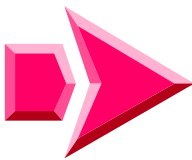


**IF THIS APPOINTMENT IS FOR YOU START HERE**



NAME			
LAST NAME		FIRST	M.I.
PREFERS TO BE CALLED BY			
ADDRESS			
CITY		STATE	ZIP
HOME PHONE			
BIRTHDATE	AGE	MALE	FEMALE
MARRIED	SINGLE	DIVORCED	WIDOWED
SOCIAL SECURITY NUMBER			
DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE			
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL			
SOCIAL SECURITY NUMBER			
If your child's last name and/or address are not the same as yours, fill in the top box also.			

**IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE**



<b>DENTAL INSURANCE</b>	
<b>PRIMARY CARRIER</b>	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NUMBER	
INSURED'S SOCIAL SECURITY NUMBER	
<b>SECONDARY CARRIER</b>	
INSURANCE COMPANY	
GROUP NO.	
EMPLOYER'S NAME	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S I.D. NUMBER	
INSURED'S SOCIAL SECURITY NUMBER	



<b>ACCOUNT INFORMATION</b>		
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



<b>GETTING TO KNOW YOU</b>		
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME?	RELATIONSHIP:	
<b>YOU WERE REFERRED TO US BY?</b>		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT IN EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP