Section I: **Patient Information** **Date_____**

Name:_____ I Prefer:_____

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

Hm Ph#:(_____)_____Wk Ph#:(_____)_____ Cell Ph#:(_____)_____

Date of Birth:_____ SS#:_____-_____-_____ Employer:_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Other

Is another member of your family already a patient at our office? ☐ Yes ☐ No

If so, whom?_____

Person to contact in case of emergency: _____ Ph#(_____)_____

Email Address:_____ May we contact you by email? _____

Section II: **Account Information**

Person financially responsible for account: ☐ Self ☐ Parent ☐ Other

Name:_____ Relationship to Patient:_____

****Please provide us with a copy of your Insurance Card****

Name of Insured:_____ DOB:_____ Relationship to Patient:_____

SS#:_____-_____-_____ Employer:_____ Ph#:(_____)_____

Insurance Company:_____ Gp#:_____ ID#:_____

PLEASE NOTIFY US IF YOU HAVE SECONDARY DENTAL INSURANCE

Section III: **HIPPA**

I,_____ have been notified of Dr. Thompson's privacy policy. I understand that I am entitiled to a copy.

SIGNATURE OF PATIENT OR GUARDIAN **DATE**