



Date: _____

Patient Information

Patient Name: _____
Last First Middle (Preferred Name)

Address: _____
Street City State Zip Apartment #

Gender: Male Female Family Status: Married Single Divorced Child Widow

Security #: _____ Driver's License #: _____ Birth Date: _____

Phone (Home): (____) _____ (Work): (____) _____ (Cell): (____) _____ Text? Y N

E-Mail Address: _____

How did you hear about Angela Gray Family Dentistry?

Radio: _____ Newspaper: _____

Current Patient: _____ Other: _____

Responsible Party Information

The Following is For: Self (same as above) Spouse Parent/Guardian

Name: _____

Security #: _____ Birth Date: _____

Phone (Home/Cell): (____) _____ (Work): (____) _____ Ext: _____ Best time to call: _____

Address: _____
Street City State Zip Apartment #

Employment Information

The Following is For: Patient Person Responsible for Patient

Employer's Name: _____ Your Occupation: _____

Address: _____ Phone: _____
Street City State Zip

Insurance Information

Primary Name of Insured: _____ Is insured a patient? Yes No
Last First Middle

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Apartment #

Insured's Employer's Name: _____
Street City State Zip

Insured's Employer's Address: _____

Patient's Relationship to Insured: Self Spouse Child Other: _____

Insurance Plan Name and Address: _____