ARBOR LAKES DENTAL

TODAY'S DATE____________

Patient's Name	**Birth date**		**Age**	**Sex:** **M F**
Home Address	**City**	**State**	**Zip**	

Home Phone #	***Please Circle One:*** Single, Married, Separated, Widowed	**Your Social Security Number**
Your Employer	**Occupation**	**Work Phone #**

Are you a full time student? ☐Yes ☐ No	*If patient is minor we need Mother & Father's Names & Birth date*

Person responsible for account:	**YOUR Driver's License Number:**	
Name of spouse (or parent if minor)	**YOUR E-mail address**	**YOUR cell phone #**

Spouse's (or parent's) employer	**Spouse's Soc. Sec. #**	**Work phone #**

EMERGENCY INFORMATION
Name, Address, & Telephone of A relative not living with you:
How did you hear about our office?
Reason for this visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)			**If you have a dual insurance coverage, complete this for the secondary coverage**		
Insured's name	**DOB**	**SS#**	Insured's name	DOB	SS#
Insured's employer			Insured's employer		
Insurance Co			Insurance Co		
Insurance Co Address			Insurance Co Address		
Phone #			Phone #		
Group #	**Policy #**		Group #		Local #

Is there anything other medical or dental history we should know?		
Patient Signature (or parent of child)	Date	Doctor's Signature