

UNIVERSITY SQUARE DENTAL ASSOC.

Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First MI

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City, State, Zip Code

Email Address: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

Whom May We Thank for referring you to this practice? \_\_\_\_\_

If the Patient is a Student or a Minor:

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Home & Business Phone: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Address: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_ Home & Business Phone: \_\_\_\_\_

Who Is Responsible for the Payment of Account? \_\_\_\_\_

Billing Address: \_\_\_\_\_

Dental Insurance Information: (Please not your medical insurance info)

Insured Employee(Policy Holder): \_\_\_\_\_ Employer's Name \_\_\_\_\_

Name of Insurance  
Company: \_\_\_\_\_

Address of Insurance Co \_\_\_\_\_

Insured ID# \_\_\_\_\_ Group# \_\_\_\_\_ Policy  
Holder's DOB \_\_\_\_\_