UPTOWN Dental

Patient Information (Confidential)

First Middle Last Sex

Name _____ M F

Address _____

City _____ State _____ Zip _____

Email _____

SS# _____ DOB _____ Age _____

Phone: Home _____ Work _____

Check Appropriate Box:

___Minor ___Single ___Married ___Divorced

___Widowed ___Separated

If College Student, ___Full time ___Part time

School Name _____

City _____ State _____

Spouse or Parent's Name _____

Emergency Contact _____

Phone _____

Dental Insurance Information Only

Name of Insured _____

Relationship to Patient _____

Home Phone _____

DOB _____ SS# _____

Employer name _____

Work Phone _____

Insurance Co. _____

Phone # _____

Ins. Group # _____

Policy/ID# _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Responsible Party

Name of Person Responsible for this Account _____

Relationship to Patient _____ Address _____

Home Phone _____ SS# _____ Driver's License # _____

DOB _____ Employer _____ Work Phone _____

Is this person currently a patient in our office? ____Y ____N

X _____ _____

Signature of Patient or Parent if Minor Date