Welcome to Troup Family Dental

Name: ____
First Middle Last Preferred Name

Address:____
Street Apt # City State Zip

Phone: (Home):_________________________ (Work): _________________________Ext: ______(Cell):_________________________

Age: ________ Gender: Female / Male Family Status: Single / Married / Divorced / Widowed

Social Security #: ______________________ Date of Birth: _______________ DL # :______________________State_______

Emergency Contact:_________________________Phone :_________________________Relationship:__________________

Preferred Pharmacy:________________________________ Previous Dentist:______________________________________

Email Address:_____________________________________

How did you hear about us? (Please, circle all that apply)

Friend/ Relative/ Dental Office/ Billboard / Mailer / Website / Facebook / Other: ______________________________

Whom may we thank for referring you to our practice? ____

Responsible Party Information

Name: ____
First Middle Last Relationship to Patient

Address: (If different from above) ____
Street City State Zip

Phone: (Home):_______________________ (Work): _________________________Ext: _______ (Cell):______________________

Social Security #: _______________________ Date of Birth: _____________________ DL # ___________________________

Primary Carrier

Insurance Company: ________________________________ Employer : ____

Group Number: ___________________________________Group Name:____

Insured's Member I.D. #: _____________________________ Insured's Social Security #: __________________________

Relationship to Patient :_______________________________

Secondary Carrier

Insurance Company: ________________________________ Employer : ____

Group Number: _____________________________________Group Name:____

Insured's Member I.D. #: _____________________________ Insured's Social Security #: __________________________

Relationship to Patient :_______________________________