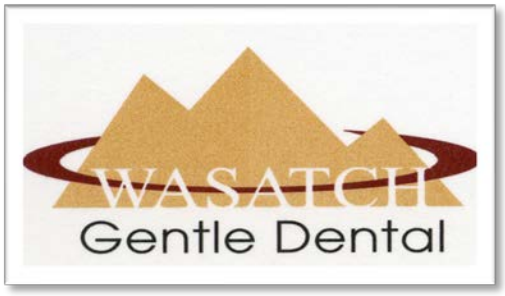

Today's date _____

Responsible Party Information

Name _____Date of Birth _____/_____/_____
Address _____City _____ State _____Zip _____
Home Phone _____Work Phone _____Cell Phone _____
Social Security Number _____**Email Address** _____
Driver's license # _____Employer _____ Phone _____
Spouse _____ SS# _____Employer _____
Phone _____Date of Birth _____/_____/_____

Who can we thank for referring you to our office? _____

Patient Information

Patient Name _____ Date of Birth _____/_____/_____Relationship _____
Address (if different than above) _____City _____ State_____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____

Patient Name _____ Date of Birth _____/_____/_____ Relationship _____
Address (if different than above) _____City _____ State_____ Zip_____
Home Phone _____ Work Phone _____ Cell Phone _____

Insurance Information

Primary Insurance
Policy Holder _____
Insurance Co _____
Phone Number _____
Date of Birth _____/_____/_____
Employer _____
Address _____
ID# _____ Group# _____

Secondary Insurance
Policy Holder _____
Insurance Co _____
Phone Number _____
Date of Birth _____/_____/_____
Employer _____
Address _____
ID# _____ Group# _____

Name of Nearest Relative Not Living With you _____Phone _____
Emergency Contact Person _____ Relationship _____ Phone _____

The above mentioned is true to the best of my knowledge. I hereby authorize Wasatch Gentle Dental, Inc. to furnish my designated insurance carrier all information concerning my present dental needs. I also authorize benefits to be made directly to Wasatch Gentle Dental, Inc.

Signature of Responsible Party _____ Date _____