

**7th St. Dental Care**  
770 E. Thunderbird Ave. • Suite A • Phoenix, AZ 85022

**PATIENT INFORMATION**

Patient Name: Dr. Mr. Mrs. Ms. Miss \_\_\_\_\_

By what name do you prefer to be called? \_\_\_\_\_

Birthday: \_\_\_\_\_ Social Security No: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different than above: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Name of Employer: \_\_\_\_\_

If full-time student, name of school: \_\_\_\_\_

Name of person responsible for account: \_\_\_\_\_

Address/Phone (if different from above): \_\_\_\_\_

Name of Spouse: \_\_\_\_\_

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

Emergency Contact Person: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Relative Not Living With You: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

**INSURANCE INFORMATION**

First Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

First Insurance Company: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Group # / Policy #: \_\_\_\_\_

Relationship to Patient:  Self  Spouse  Child  Other \_\_\_\_\_

*(Please complete the back side of this form)*