Patient Information **DRS. ALBRIGHT SMITH & PECK**

Last Name_____ First Name_____ Middle Initial_____Age_____
Mr / Dr/ Mrs/ Miss/ Ms **O** Male **O** Female **O** Single **O** Married **O** Widowed **O** Divorced

MailingAddress:_____City_____zip_____
Home Phone_____ Work Phone_____Cell Phone _____
Social Security Number_____ Date of Birth_____Email_____
Employer _____Occupation _____ Empl Add:_____
If College Student: Name of School_____ City_____ State _____FT or PT
If Married Spouse Name _____ Spouse Phone _____

Emergency Contact
Name:_____Relationship_____Phone_____

Account Information

O Person responsible for account is the same as above Yes or No---- If not the same as above please fill out below.

Last Name _____ First Name _____ Middle Initial _____
MailingAddress_____City_____State_____Zip_____
Date of Birth_____ **O** Male **O** Female **O** Single **O** Married **O** Widowed **O** Divorced
Home Phone _____ Work Phone _____ Cell Phone _____
Social Security Number _____ Drivers License Number _____State____
Email_____Occupation_____Employer_____
Employer Phone _____

Insurance Information

	Primary Dental	Primary Medical	Secondary Dental	Secondary Medical
Insurance Company				
Subscriber Name				
Subscriber Employer				
Relationship to patient				
Insured ID# SS Number				
Group Number				
Insurance Address				
Insurance Phone				

PLEASE COMPLETE

General Dentist _____ **Phone** _____
Referred to us by _____ **Phone** _____