UAB SCHOOL OF DENTISTRY

Date:_____

☐ New Patient

☐ Returning Patient

PATIENT INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL			DATE OF BIRTH	GENDER ☐ MALE ☐OTHER ☐ FEMALE
ETHNICITY ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ American Indian or Alaskan Native ☐ Unknown ☐ African American ☐ Hispanic or Latino ☐ Two or More Races ☐ White, Not Hispanic				
STREET ADDRESS	CITY	STATE		ZIP CODE
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER		CELL PHONE NUMBER
EMAIL ADDRESS	NAME AND ADDRESS OF EMPLOYER	SIGNATURE		

RESPONSIBLE PARTY (IF NOT PATIENT)

LAST NAME FIRST NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE
STREET ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER
NAME AND ADDRESS OF EMPLOYER		SIGNATURE	

EMERGENCY CONTACT

PERSON TO CONTACT OTHER THAN SPOUSE	RELATIONSHIP TO PATIENT
ADDRESS, CITY, STATE, AND ZIP	PHONE NUMBER
PATIENT'S PHYSICIAN	PATIENT'S PHYSICIAN'S PHONE NUMBER

PRIMARY DENTAL INSURANCE INFORMATION

INSURED'S LAST NAME FIRST NAME MIDDLE	RELATIONSHIP TO PATIENT	INSURED'S DATE OF BIRTH	INSURED'S GENDER ☐ MALE ☐ FEMALE
INSURED'S STREET ADDRESS	CITY	STATE	ZIP
INSURANCE COMPANY NAME		COMPANY PROVIDING INSURANCE	
CONTRACT NUMBER	GROUP NUMBER	INSURED'S SOCIAL SECURITY NUMBER	
SIGNATURE			