Brian Barron, DMD

Patient Name: _____ **Gender:** _____ **Marital Status:** _____

Birth Date: _____ **SS#** _____ **Email** _____

Phone: _____ **Cell:** _____ **Work:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Employer: _____ **Employer Phone:** _____

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

Responsible Party Information

Name: _____ **Gender:** _____ **Marital Status:** _____

SS# _____ **Birth Date:** _____

Phone: _____ **Cell:** _____

Address: _____

Emergency Information

In case of emergency, whom shall we call? _____ **Phone:** _____

Primary Insurance Information

Insured: _____ **Birth Date:** _____ **ID or SS#** _____

Name of Ins. Co: _____ **Phone:** _____

Address: _____

Employer: _____ **Group #** _____ **Patient's relationship to Insured:** _____

Secondary Insurance Information

Insured: _____ **Birth Date:** _____ **ID or SS#** _____

Name of Ins. Co: _____ **Phone:** _____

Address: _____

Employer: _____ **Group #** _____ **Patient's relationship to Insured:** _____

_____ Date: _____

Signature of Patient or Responsible Party