<table>
<tr><th colspan="4">PATIENT INFORMATION</th></tr>
<tr><td>Patient's Last Name:</td><td>First Name:</td><td>Preferred:</td><td>Middle:</td></tr>
<tr><td colspan="2">Social Securtiy number</td><td>Date of Birth</td><td>Sex: Male ☐
Female ☐</td></tr>
<tr><td colspan="4">Marital Status: Single ☐ Married ☐
Separated ☐ Divorced ☐ Widow ☐</td></tr>
<tr><td>Mailing Address:</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Physical Address:</td><td>City</td><td>State:</td><td>Zip:</td></tr>
<tr><td colspan="2">Email Address:</td><td colspan="2">Family Members Who Are Seen In This Office:</td></tr>
<tr><td>Home Phone:</td><td>Work Phone:</td><td colspan="2">Cell Phone:</td></tr>
<tr><td>Employer:</td><td>Preferred Pharmacy:</td><td colspan="2">How Did You Hear About Our Office?</td></tr>
<tr><td>Emergency Contact:</td><td>Emergency Contact Relationship:</td><td colspan="2">Emergency Contact Phone:</td></tr>
</table>

<table>
<tr><th colspan="2">PRIMARY INSURANCE</th><th colspan="2">SECONDARY INSURANCE</th></tr>
<tr><td colspan="2">Insured's Name:</td><td colspan="2">Insured's Name:</td></tr>
<tr><td>Insured's Date of Birth:</td><td>Relationship To Patient:</td><td>Insured's Date of Birth:</td><td>Relationship To Patient:</td></tr>
<tr><td colspan="2">Employer</td><td colspan="2">Employer</td></tr>
<tr><td colspan="2">Insurance Co.</td><td colspan="2">Insurance Co.</td></tr>
<tr><td colspan="2">Insurance Co. Phone:</td><td colspan="2">Insurance Co. Phone:</td></tr>
<tr><td>ID#:</td><td>Group#:</td><td>ID#:</td><td>Group#:</td></tr>
</table>

Acknowledgement of Notice of Privacy Practices

I give River City Dental, Inc. permission to leave messages and/or other pertinent information at my home, and/ or voice mail, e-mail or at my place of employment per my request. Initials: _______________

I, ____________________, have been provided access to a copy of this office's Notice of Privacy Practices.

_____________________________________ _____________________________________

Patient/Guarantor Signature Date