



PLEASE PRINT CLEARLY

CONTACT INFORMATION:

FIRST NAME		MIDDLE INITIAL	LAST NAME		TITLE <input type="checkbox"/> Mr. <input type="checkbox"/> Other: <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	
DATE OF BIRTH			EMAIL ADDRESS			
MAILING ADDRESS				APT. #	CITY	
STATE	ZIP CODE	APPT. REMINDER TYPE <input type="checkbox"/> Call to Primary Phone <input type="checkbox"/> Text to Primary Phone <input type="checkbox"/> E-mail	PRIMARY PHONE # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work		SECONDARY PHONE # <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	

DEMOGRAPHIC INFORMATION:

This information helps us provide the best possible care to all patients. Your answers are confidential and will never affect your status as a patient.

RACE (Choose all that apply): <input type="checkbox"/> American Indian/Alaskan Native Female <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Prefer not to say	ETHNICITY: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Prefer not to say	PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> 广东话 (Cantonese) <input type="checkbox"/> 普通话 (Mandarin) <input type="checkbox"/> Español <input type="checkbox"/> Haitain kreyòl <input type="checkbox"/> Português <input type="checkbox"/> Other:	HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> Recommended by friend or family <input type="checkbox"/> Recruited by dental student <input type="checkbox"/> Referred by outside dentist <input type="checkbox"/> Street sign/presence <input type="checkbox"/> Online search or review site <input type="checkbox"/> Advertisement <input type="checkbox"/> Other:
	GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Prefer not to say		

EMERGENCY CONTACT:

FIRST NAME	LAST NAME	PHONE	RELATIONSHIP TO PATIENT
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DENTAL INSURANCE INFORMATION:

DENTAL INSURANCE TYPE <input type="checkbox"/> Blue Cross Blue Shield (MA/RI) <input type="checkbox"/> Senior Whole Health <input type="checkbox"/> Cigna <input type="checkbox"/> Tufts Health Forward <input type="checkbox"/> Commonwealth Care Alliance <input type="checkbox"/> Tufts Health Unify Plan <input type="checkbox"/> Delta Dental <input type="checkbox"/> No Insurance <input type="checkbox"/> MassHealth <input type="checkbox"/> Other:	SUBSCRIBER NAME	SUBSCRIBER DATE OF BIRTH
	SUBSCRIBER ID#	RELATIONSHIP TO PATIENT

AUTHORIZED PERSONAL REPRESENTATIVE (if applicable):

FIRST NAME	LAST NAME	TITLE <input type="checkbox"/> Mr. <input type="checkbox"/> Other: <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
PHONE	RELATIONSHIP TO PATIENT <input type="checkbox"/> Legal Guardian/Custodian <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Other (Describe relationship to patient.):	