Patient Information

Patient Name: ______________________________ Date: ____________
Last First MI

Driver's License #: ____________ E-Mail Address: ____________

☐ Male ☐ Female Marital Status ________ Social Security #: ____________ Birth Date: ____________

Address: ____
Street Apartment #
____
City State Zip Code

Phone (Home): ____________ (Work): ____________ Ext: ______ (Cell) ____________

In case of an emergency call ______________________ Phone ____________

Referral Information

Whom may we thank for referring you to our practice? ____________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ____________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: ____________

Address: ____
Street Apartment #
____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ____________ Occupation: ____________

Address: ____

Dental Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ____________ SS #: ____________ Group #: ____________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________

Insurance Plan Name and Phone#: ____________