PATIENT INFORMATION

This information is necessary for our files and will be considered confidential

Patient's Name:______________________________ Birth Date:__________
Last First M.I

Residence Address:______________________________
Street City State Zip

Residence Phone:(______)____________ Social Security No.:______________

Cell Phone: (______)____________ Email Address:______________

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed Sex: ☐ M ☐ F

Employer:______________________________

Business Address:______________________________
Street City State Zip

Business Phone:(______)____________ Occupation:__________ How Long:________

Former Dentist:______________ Phone:(______)__________ City:__________

Date of last exam:______________ Date of last dental x-rays:______________

If attending school, name of school:______________________________

Name of dependents:______________________________

Whom may we thank for referring you?______________________________

Person responsible for this account:______________________ Relationship:__________

Address:______________________________ Phone:(______)__________
Street City State Zip

Primary Insurance Company:

Insured Person:______________________ ____________ ____________ ____________
Name Social Security No. Date of Birth Relationship

Employer:______________________________
Name and Address

Insurance Co.:______________________ ____________ ____________
Name and Address Group No. Plan No.

Union Name:____________ Local:______________

Secondary Insurance Company:

Insured Person:______________________ ____________ ____________ ____________
Name Social Security No. Date of Birth Relationship

Employer:______________________________
Name and Address

Insurance Co.:______________________ ____________ ____________
Name and Address Group No. Plan No.

Union Name:____________ Local:______________

As a courtesy, our office will bill your insurance company. However, you will be responsible for any outstanding balance.

SIGNATURE:______________________________ **DATE:**__________