PATIENT INFORMATION

Date: _____

Patient No.

Please print patient's last name:

EMAIL ADDRESS _____

First Name: _____ Home Phone: _____ Office Phone and ext.: _____

Home Address: _____ City / Zip: _____

Birthdate: _____ Age: _____ SS#: _____ Driver's License: _____

Employer: _____ Address: _____ City / Zip: _____

Occupation: _____ Marital Status: Single: ❑ Married: ❑ Divorced: ❑ Separated: ❑ Widowed: ❑

If married, Spouse's Name, Birthdate and Employer: _____

If full-time student, School Name and Address: _____

If you are covered by parents' insurance or under 18 years of age:

Father's Name: _____ Birthdate: _____

Mother's Name: _____ Birthdate: _____

Who is responsible for bills not covered by insurance? Patient ❑ Spouse ❑ Parent ❑ Other ❑

Name: _____ Address: _____ City / Zip: _____

Employer: _____ Wk. Address: _____ Wk. Phone: _____

PRIMARY DENTAL INSURANCE: _____ ID #: _____

Policyholder: _____ Employer: _____ Group #: _____

SECONDARY DENTAL INSURANCE: _____ ID #: _____

Policyholder: _____ Employer: _____ Group #: _____

PRIMARY MEDICAL INSURANCE: _____ ID #: _____

Policyholder: _____ Rel. to Pt.: _____ Group #: _____

SECONDARY MEDICAL INSURANCE: _____ ID #: _____

Policyholder: _____ Rel. to Pt.: _____ Group #: _____

Who referred you to our office? _____ D.D.S. ❑ M.D. ❑ D.O. ❑ Friend ❑ Phone Book ❑

In case of emergency, please contact: _____ Phone #: _____ Rel.: _____