Patient Information

Patient Name:_____ Date:_____
Last First MI

Address:_____
Street Apartment#

_____
City State Zip Code

Phone (Home):_____(Work):_____Ext:_____(Cell):_____

Birth Date:_____Social Security #:_____

☐Male ☐Female ☐Married ☐Single ☐Child ☐Other_____

Best Time To Call:_____Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

E-Mail Address:_____

Insurance Information

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

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insured's Employer Name:_____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐Other_____

Insurance Plan Name and Address:_____

_____

Phone:_____

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

Insured's Birth Date:_____ ID #:_____ Group #:_____

Insured's Employer Name:_____

Insurance Plan Name and Address:_____

_____

Phone:_____

Spouse of Responsible Party Information

The Following is for: ☐ Patient's Spouse ☐Person Responsible for Payment

Name:_____ ☐ Male ☐ Female

☐ Married ☐Single ☐ Child ☐Other_____

Social Security #:_____ Birth Date:_____

Phone (Home):_____(Work):_____Ext:_____(Cell):_____

Best Time To Call:_____

Address:_____
Street Apartment#

_____
City State Zip Code

Person to Contact in case of Emergency:_____Relationship:_____

Phone (Home):_____(Work):_____Ext:_____(Cell):_____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Yellow Pages Newspaper

☐ School- ☐ Work ☐ Other_____

Name of person or office referring you to our practice:_____