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PATIENT INFORMATION

Welcome to our office! Please fill out this form completely in ink. All information is kept confidential. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient's Name: _____ Today's Date _____

How would you like to be addressed: _____

Sex: _____ Age: _____ Birth Date: _____ Soc. Sec. # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____ Address: _____

If full time student, name of school _____ Name of Spouse or Parent: _____

Responsible Party's Name: _____

Family members who have been patients here: _____

Nearest relative NOT living with you: _____ Phone: _____

Whom may we thank for referring you to our office? _____

Previous Dentist: _____ Address: _____

Insurance Company: _____ Phone: _____

Address: _____

Insured: _____ Birth Date: _____ Soc. Sec. # _____

Relationship to Insured: _____ Employer: _____ Group Number: _____

Secondary Insurance Company: _____ Phone: _____

Address: _____

Insured: _____ Birth Date: _____ Soc. Sec. # _____

Relationship to Insured: _____ Employer: _____ Group Number: _____