PATIENT INFORMATION SHEET

Date: _____ Referred by: _____

Patient's Name: _____ SSN: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Sex: M F Marital Status: M S W D

Email Address: _____

Employer: _____ Work Phone: _____

Name of Spouse: _____ SSN: _____

Spouse's Employer: _____ Work Phone: _____

Emergency Contact: _____ Phone: _____

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

DOB: _____ SSN: _____ Employer: _____

Home Phone: _____ Work Phone: _____

Email Address: _____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE (Use your identification card)

Insured/Subscriber's Name: _____ SSN: _____ DOB: _____

Patient's Relationship to Insured/Subscriber: Self _____ Spouse: _____ Child: _____ Other _____

Insurance Company: _____ ID#: _____ Group#: _____

Claims Address: _____ Phone: _____

SECONDARY INSURANCE (Use your identification card)

Insured/Subscriber's Name: _____ SSN: _____ DOB: _____

Patient's Relationship to Insured/Subscriber: Self _____ Spouse: _____ Child: _____ Other _____

Insurance Company: _____ ID#: _____ Group#: _____

Claims Address: _____ Phone: _____