PATIENT INFORMATION (CONFIDENTIAL)

ID#____________________

NAME____ DATE____________________
FIRST MI LAST

ADDRESS____________________ CITY____________________ STATE_______ ZIP__________

SS#____________________ HOME PHONE____________________ WORK PHONE____________________

BIRTHDATE____________________ EMPLOYER____________________ E-MAIL:____________________

IF STUDENT, F.T./P.T., NAME OF SCHOOL____

PERSON TO CONTACT IN CASE OF AN EMERGENCY____________________ PHONE____________________

WHOM MAY WE THANK FOR REFERRING YOU?____

RESPONSIBLE PARTY (IF DIFFERENT THAN ABOVE, PLEASE FILL OUT)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT____________________ RELATIONSHIP TO PATIENT____________________

ADDRESS____ HOME PHONE____________________

BIRTHDATE____________________ SS#____________________

EMPLOYER____________________ WORK PHONE____________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

PRIMARY DENTAL INSURANCE INFORMATION

SUBSCRIBER NAME____ RELATIONSHIP TO PATIENT____________________

BIRTHDATE____________________ SS#____________________

NAME OF EMPLOYER____________________ UNION OR LOCAL#__________ WORK PHONE____________________

EMPLOYER ADDRESS____________________ CITY____________________ STATE_______ ZIP__________

INSURANCE CO.____________________ TEL#__________ GRP#__________ POLICY#____________________

INS. CO. ADDRESS____________________ CITY____________________ STATE_______ ZIP__________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE BELOW

SECONDARY DENTAL INSURANCE

NAME OF INSURED____ RELATIONSHIP TO PATIENT____________________

BIRTHDATE____________________ SS#____________________

NAME OF EMPLOYER____________________ UNION OR LOCAL#__________ WORK PHONE____________________

EMPLOYER ADDRESS____________________ CITY____________________ STATE_______ ZIP__________

INSURANCE CO.____________________ TEL#__________ GRP#__________ POLICY#____________________

INS. CO. ADDRESS____________________ CITY____________________ STATE_______ ZIP__________

Authorization to release information to the insurance company:

X____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR