Patient Information Form

Please complete the following information

Date: _______________

Name: ______________________________ Hm Phone: _______________ Wk Phone: _______________________
Cell Phone: _____________________ E-mail address: _______________________ Pager #: ___________________
Home Address: _________________________ City: ______________________ St: _______ Zip Code___________
Social Security #: _______________________ Date of Birth: (Month/Day/Year)_____________________________
Circle One: Married Single Divorced Widowed Driver's License #: ______________________
Occupation: ____ Employer: _________________________________

Your Spouse

Spouse Name: _________________________________ Birthday (Month/Day/Year) _________________________
Home Address: _____________________________ Hm Phone: __________________ Wk Phone: ______________
City, State, & Zip: ______________________________ Social Security #: __________________________________
Employer: ____ Occupation: ________________________________

Dental Insurance

- Dental Insurance Company: ____
- Address: ____
- City, State, Zip Code: ____
- Telephone: ____
- Group or Policy #: ____

Getting to Know You

Is any other member of your family a patient at our office? ____
Their name? ____________________________________ Relationship? ____________________________________
Whom can we thank for referring you to our office? ____
Nearest Relative not living with you: ____________________________ Phone: _______________________________
Physician: ____Phone: __________________________________
Whom may we contact in case of an emergency? _____________________________ Phone: __________________

Account Information

Who is responsible for this account? ___________________________Phone: ________________________________
Address (if different than above) ________________________ City: ______________ St: _______Zip: __________
Employer: ___________________________ Bus. Address: ___________________ Bus. Phone: __________________
Dental Insurance Co: ___________________________ Phone #: ___________ Policy #: ________________________
I will be paying by cash ______________________ check: ________________ credit card: ____________________

I authorize release of any information relating to my dental claim. I authorize payment directly to the Dentist of the group insurance benefits otherwise payable to me.

Signature of responsible party: ____