Patient Information Sheet

Please print the required information:(your social will not be entered into our computer system)

Patient Name: ____
Last ***First*** ***Middle***

Address: ____
Street **City** **State** **Zip**

Social Security Number: ______-______-______ **D.O.B.:** ____/____/____ **Male** or **Female**

Marital Status: Single Married Divorced Other__________________
Employed: Full-Time Part-Time Self-Employed Other__________________

Home Phone: ____________________ Cell Phone: ____________________
Work phone: ____________________ Name of Employer: ____________________
E-mail: ____________________ Sudent: Full Time Part-time None
Pharmacy Name: ____________________ Pharmacy Phone: ____________________

*****In Case of Emergency, Please notify:***

____________________ ____________________ ____________________
Name ***Phone #*** ***Relationship to patient***

Who referred you to our practice? ____________________ Phone#: ____________________
Name of your previous dentist: ____________________ Phone#: ____________________
When did you last see this dentist? ____________________

Do you have Dental Insurance? YES or NO (If yes, please complete the information below)

Primary Insurance*	**Secondary Insurance**
Primary Policy holders Name: ____________	Primary Policy holders Name: ____________
DOB ____/____/____ SS# ______-______-______	DOB ____/____/____ SS# ______-______-______
Relationship to Patient: ____________	Relationship to Patient: ____________
Name of Insurance Co.: ____________	Name of Insurance Co.: ____________
Claims Address: ____________	Claims Address: ____________
City: ____________State: ______ Zip: ______	City: ____________State: ______ Zip: ______
Policy ID#: ____________	Policy ID#: ____________
Group #: ____________Phone #:____________	Group #: ____________Phone #:____________

*Person Financially responsible for patients account:

(Required for patients under 18years of age and patients who are unable to make Legal decisions for themselves)

____________________ ______-______-______ ____/____/____
Name(Last, First, Middle) ***Social Security#*** ***DOB***

____________________ ____________________
Street Address (Suite, Apt. #) **Phone #**

____________________ ____________________
City and Zip **Relationship to patient**

* We are not affiliated with any insurance companies. If your insurance covers out-of-network you *may* be reimbursed.