Patient Information Form

Patient Name: ______________________________ **Preferred/Nick Name:** ______________
(Last) (First) (Middle Initial)

☐ **Single** ☐ **Married** ☐ **Child** ☐ **Widowed** **DOB**: ______/______/______ **SSN:** _________-________-_________

Address:____ **Apt #:** ___________________

City: ______________________________ **State:** __________________ **Zip Code:**________________

Email: ____ **Hm Ph #:** (_______)________________
(Used to Confirm Appointments)

Wk Ph #: (_______)______________ **Cell Ph #:**(_______)_______________ **Best # to Reach You:** Hm / Wk / Cell

Employer Name: ____ **Emp Ph #:** (______)______________

Employer Address: ____

City: ______________________________ **State:** __________________ **Zip Code:**________________

Primary Care Physician: ___________________________________ **Ph #**: (_______)________________

Landlord/Apt. Complex: ____________________________________ **Ph #**: (_______)________________
(if you do not own your home)

Emergency Contact: ____ **Ph #:** (_______)________________

Whom may we thank for referring you? __________________________ **Ph #:** (_______)________________

Who is responsible for this Account? ☐ Same as Above ______________________________________

Address: ____ **Hm Ph #:** (_______)________________

SSN: ________-________-________ **DOB**: ______/______/______ **Wk Ph #:** (_______)________________

Primary Dental Insurance Information

Insurance Company: ____________________________________ **Ins Ph #:** ______________________

Claim Address: _______________________________________ **Group #:** _______________________

Subscriber Name: ☐ Same as Above ____
(Who's the employee)

SSN/ID#: ___________________ **DOB**: ______/______/______ **How long with this Employer?** ____________

Employer/Group Name: __________________________________ **Emp Ph #:** (_______)______________

Employer Address: ____

City: ______________________________ **State:** __________________ **Zip Code:**________________

Who is Covered Under this Policy? ____

Do You have Secondary Insurance Coverage? ☐ **Yes** ☐ **No**

____ **Date**: ______________________
Signature

____
Parent/Guardian Name (if minor)