PATIENT INFORMATION FORM

(Questions may be duplicated on these forms, but are required for legal and medical reasons.)

M_____ Date_____
(Patient's name)

Home Phone_____ Office Phone_____ Cell Phone_____

Home Address_____ City_____ Zip_____

Date of Birth _____ Marital Status:___S___M ___D ___W

Spouse's Name_____ **Referred by**_____

Social Security #_____ Driver's License #_____

Your Occupation_____ Employer/School Attending_____

Employer's Address_____ City_____ Years with firm_____

Previous Dentist _____ Address_____

City _____ State _____ Zip_____ Phone _____

Spouse's Occupation_____ Employer_____
(if dependent-parent's occupation)

Employer's Address _____ Years with firm_____

Person financially responsible_____ Relationship to you _____

Billing Address_____ City_____ Zip_____

(In case of an emergency in this office)
Emergency Contact Name:_____

Phone #_____ Relationship to you_____

IF YOU HAVE DENTAL INSURANCE:

Name of Insurance Co._____

Subscriber's Name_____

Social Security #_____

Subscriber's birth date_____

Group/Plan #_____

Employer _____

Insurance Co. Address_____

City_____State_____Zip_____

Telephone_____

SECOND DENTAL INSURANCE (if applicable):

Second Insurance_____

Subscriber's Name_____

Social Security #_____

Subscriber's birth date_____

Group/ Plan #_____

Employer_____

Insurance Co. Address_____

City_____State_____ Zip_____

Telephone_____

Revised Form: 5-23-05