PATIENT INFORMATION

Please Print

Patient Information:

Name____

(First) (Middle) (Last)

Social Security # ______________________ Date of Birth______________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced Sex: ☐ Male ☐ Female

Home Address____

(Street) (City) (State) (Zip)

Home Phone______________________ Cell Phone______________________

Employer ______________________ Occupation (type of work done) ______________

Address ______________________ Business Phone______________________

If Student (school & location) ______________________

Name of Family Doctor ______________________

Drug Allergies ______________________

Current Medications Being Taken______________________

Person Financially Responsible for Payment of Medical Account:

Same as Patient, Check ☐

Name______________________ Social Security #______________________

Home Address____

(Street) (City) (State) (Zip)

Home Phone______________ Cell Phone______________ Date of Birth______________

Employer______________________ Occupation (type of work done) ______________

Address______________________ Business Phone______________________

Name of Spouse or Other Parent:

Name ______________________ Social Securtity #______________________

Home Address____

(Street) (City) (State) (Zip)

Home Phone______________ Cell Phone______________ Date of Birth______________

Employer______________________ Occupation (type of work done)______________

Address______________________ Business Phone______________________

Patient's Dental Insurance:

Insurance company Name ______________________ Address______________________

Name of Policy Holder______________________ Policy ID# or SS#______________________

Date of Birth –Policy Holder______________ Group #______________ Phone #______________

Other Information :

Name, relationship & phone number of relative not residing with you______________________

Family member seen in this office ______________________

Who do we thank for this referral ______________________

Reason for Today's Visit:______________________

"I verify the accuracy of the information that I have provided on this form."

Patient Signature______________________ **Date**______________________

(or guardian/guarantor if under the age of 19)