Patient Information Form

How did you hear about our office?

☐ Current Patient ☐ Insurance ☐ Internet/Website ☐ Mailing ☐ Family/Friend

☐ Event ☐ Social Media ☐ Dental Office ☐ Other ________________________________

Name ________________________ ______________________ _______________ Gender ________________

Last First MI

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. How do you wish to be addressed:______________________

Address:____

Mailing Address City State Zip

Home Phone: ___________________ Work Phone: ____________________ Cell Phone: ______________________

Email Address: ____

Date of Birth: ___________________ Social Security #: ________________ Employer: ______________________

Responsible Party Name: ____ Phone: _________________________

Emergency Contact Name: ____ Phone: _________________________

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name: ____

Employee/Subscriber Name:____

Last First MI

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: __________ Subscriber ID #: _____________

Group/Employer Name:____ Group Number: ________________

Secondary Insurance Company Name: ____

Employee/Subscriber Name:____

Last First MI

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: __________ Subscriber ID #: _____________

Group/Employer Name:____ Group Number: ________________

Thank you for choosing our practice. We appreciate your confidence in our care and services.