PATIENT INFORMATION SHEET

Patient's Name: First _____________________________M.I. ______ Last _____________________________
Address: _____________________________________City: _______________State: _____Zip Code: ________
Date of Birth: M______D______Y______ Age: _________ Social Security #___________________________
Home Tel: (____)________________________Work Tel: (____)______________________
Are you: ___Married ___Divorced ___Legally Separated ___Widow ___Single Sex: ___ M ___F
ARE YOU A STUDENT? ______Full _____Part Time
School Name/Address:
____
Employer Name: _______________________________ Address:_____________________________________
Occupation:_____________________________________
Spouse's Name: ________________________________ Work Tel: (____)________________________
Spouse's Employer: __________________________Occupation: ________________________________
Who is Your Dentist? _________________________ Who is your physician? ___________________________
What is the reason for your visit? ____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT? (PLEASE CIRCLE ONE) SELF SPOUSE MOTHER FATHER OTHER
IF MOTHER, FATHER OR OTHER PLEASE CONTINUE:
Name: First_________________________ M.I.______ Last_____________________________________
Social Security #_______________________________ Home Tel: (_____)__________________________
Address Street: _______________________________ City: _____________ State: _____ Zip Code: _______
Employer: ______________________________ Work Tel: (_____)____________________

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insurance Co: ____
Address of Ins. Co: ____________________________City: _____________ State: _____ Zip Code:________
Phone: (____)____________________________________Group #_____________________
Name of Insured: ____Date of Birth: _____________________
Social Security #_________________________
Employer: ____

SECONDARY DENTAL INSURANCE INFORMATION:

Name of Insurance Co: ____
Address of Ins. Co: ____________________________ City: _____________State: _____ Zip Code:________
Phone: (____)____________________________________ Group #______________________
Name of Insured: ____Date of Birth: _____________________
Social Security #_________________________
Employer: ____

To the best of my knowledge, the questions on this form have been accurately answered.

Signature: _______________________________________ Date: ________________