Confidential Patient Information

Patient Name:_____ Date:_____
Last First MI

Preferred Name:_____ ☐ Male ☐ Female

Family Status: ☐ Married ☐ Single ☐Widowed ☐ Divorced

Social Security #: _____ Date of Birth:_____

Phone: (Home)_____ (Work)_____ (Ext)_____

Cell Phone:_____ Best # to Call:_____

Address:_____
Street City State Zip Code

Email Address:_____

Patient Employer:_____ Position_____

Whom may we thank for referring you? ☐Another Patient, name _____

☐ Dental or Medical Office, name:_____ ☐ Yellow Pages ☐ Newspaper

☐ Work ☐ Internet ☐ Other _____

Responsible Party Information

Name:_____ Relationship to Patient: ☐Self ☐Parent ☐Spouse

Social Security #:_____ Date of Birth:_____

Phone: (Home)_____ (Work/Ext)_____ (Cell)_____

Address:_____

Dental Insurance Information (Not Medical)

Name of Policyholder:_____

Is policyholder a patient? ☐Yes ☐No Policyholder's Date of Birth:_____

Policyholder's Address:_____

Patient's Relationship to Policyholder: ☐ Self ☐ Spouse ☐ Child ☐ Other

Policyholder's Employer & Address:_____

_____

Insurance Plan Name and Address:_____

_____

Identification Number:_____Group Number:_____