Patient Information Sheet

Date: _____

Please Print Clear Block Letters

PATIENT INFORMATION:			
Name: (Last)	(First)	(Middle)	□ Married □ Single □ Minor
Date Of Birth:	**SSN:**	**Drivers License:**	
Current Address:			
City:	**State:**	**ZIP Code:**	
Cell Phone:	**Home Phone:**	**Work Phone:**	
Person Responsible For Account: □ Patient □ Guardian □ Spouse □ Father □ Mother **Name:**			
Email Address: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ @ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___			

Please Print Block Letters Clearly

PRIMARY INSURANCE INFORMATION:			
Insurance Company Name:			
ID#:	**Group #:**	**Date of First Coverage:**	
Have You Used This Insurance? □ Yes □ No	**When / Date:**		
Do you have Dual Coverage? □ Yes □ No	**Spouse:**		
Insurance Mailing Address:			
City:	**State:**	**ZIP Code:**	
Insurance Phone #:			
Insured's Members Name: (LEAVE BLANK IF SAME AS ABOVE)			
SSN #:	**Member ID #:**	**Insured Date Of Birth:** **Patient's Relationship To Insured:** □ Self □ Spouse □ Child	

Whom Can We Thank For Referring You To Our Office? (Referral Source)	**Relationship:**	**Internet site:**
Current Employer:	**Occupation / School (If Student):**	
Employer Address:	(City / State)	(Zip Code)
Do you have dental examinations on a routine basis?	**Last Dental Visit:**	
Previous Dentist: (Name) (Address/City)	**Date of Last X-rays:**	**Date of Last Cleaning:**

EMERGENCY CONTACT:			
Name:		**Relationship:**	
Address:			
City:	**State:**	**ZIP Code:**	**Phone:**

Credit Card Info: