PATIENT INFORMATION

(please print)

PATIENT:

NAME ______________________ YEAR OF PRIOR VISIT TO THIS OFFICE ________ AGE ________ BIRTHDATE ________

ADDRESS ____

HOME PHONE NO. (   )   - ______________ SPOUSE'S NAME ______________________

SOCIAL SECURITY NO. ______________________

EMPLOYER'S NAME ______________________ BUSINESS PHONE NO. (   )   - ________ EXTENSION: ________

EMPLOYER'S ADDRESS ____

NEAREST RELATIVE NOT LIVING WITH YOU ______________________ PHONE (   )   - ________

PERSON TO BE CONTACTED IN CASE OF EMERGENCY ______________________ PHONE (   )   - ________

REFERRED TO THIS OFFICE BY: DENTIST ____________ PHYSICIAN ____________ FRIEND/RELATIVE ____________

HAS A FRIEND OR RELATIVE BEEN A PATIENT OF OUR OFFICE (SO THAT WE MAY THANK THEM FOR THEIR CONFIDENCE)?

NAME ______________ ADDRESS IF KNOWN: ______________ APPROX. YEAR OF THEIR VISIT ________

PERSON RESPONSIBLE FOR THE BILL IF THE PATIENT IS A MINOR:

NAME ____

ADDRESS ____

HOME PHONE NO. (   )   - ______________ SOCIAL SECURITY NO. ______________________

EMPLOYER'S NAME ______________________ BUSINESS PHONE NO. (   )   - ________ EXTENSION ________

EMPLOYER'S ADDRESS ____

INSURANCE INFORMATION

DENTAL: ____
(Primary carrier) Plan name | Subscriber's name | ID # | Group #

DENTAL: ____
(Secondary carrier) Plan name | Subscriber's name | ID # | Group #

MEDICAL: ____
(Primary carrier) Plan name | Subscriber's name | ID # | Group #

MEDICAL: ____
(Secondary carrier) Plan name | Subscriber's name | ID # | Group #

Please advise us if you are covered by **MEDICARE:**

☐ yes ☐ no (if yes, please read other side)

CERTIFICATION:

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on BOTH sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

DATE ______________ SIGNATURE ______________________________

(please sign in presence of office representative)

DATE ______________ WITNESS ______________________________