Patient Information Form

Today's Date _____

Patient Information

Patient's Name: _____ SSN: _____
Last First MI

Date of Birth: _____ Sex: M / F Marital Status: S / M / D / W Spouse's Name: _____

Mailing Address: _____
Apt / Lot # City State Zip Code

Street Address: _____
Apt / Lot # City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Patient Employed By: _____

Did someone refer you to us? Yes ☐ No ☐ Referred by: _____
Name Address Phone

Account Holder Information (person financially responsible for patient named above)

Account Holder Name: _____ SSN: _____
Last First MI

Mailing Address: _____
Apt / Lot # City State Zip Code

Street Address: _____
Apt / Lot # City State Zip Code

Home Phone: _____ Work Phone: _____ Employed By: _____

Do you have dental insurance? Yes ☐ No ☐

If yes, please fill out coverage information below and provide us with your insurance card.

Primary Dental Insurance Coverage

Insurance Co.: _____ Phone No.: _____

Address: _____
Street or Box City State Zip Code

ID Number: _____ Group Number: _____

Name of Policyholder: _____ Birth Date: _____ SSN: _____

Policyholder Employed by: _____ Work Phone: _____

Policyholder's relationship to patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

Secondary Dental Insurance Coverage

Insurance Co.: _____ Phone No.: _____

Address: _____
Street or Box City State Zip Code

ID Number: _____ Group Number: _____

Name of Policyholder: _____ Date of Birth: _____ SSN: _____

Policyholder Employed by: _____ Work Phone: _____

Policyholder's relationship to patient: Self ☐ Spouse ☐ Parent ☐ Other ☐

Please Complete Medical History on Other Side