Patient Information Form

Patient Name: First_____Last_____preferred nickname_____
Address:
Street_____City_____State_____Zip_____
Phone:
Mobile_____Home_____Work_____

Social Security #_____Date of Birth_____

Employer_____Occupation_____

Work Location: City_____State_____ Full time student? ☐Yes School_____

Sex: ☐Male ☐Female Marital Status: ☐Married ☐Single ☐Divorced

In case of emergency, who should be notified?_____
Relationship to patient_____ phone_____ ☐Mobile ☐Home ☐Work

Is the patient a minor? ☐Yes ☐No
Name of parent or legal guardian _____
Parent/Guardian's phone:_____ ☐Mobile ☐Home ☐Work

Dental Insurance Information- skip if already provided over phone/email. Please present or email a picture of insurance card if applicable.

Primary Dental Plan Company Name _____
Insurance Phone Number as listed on card _____
**Is the patient a dependent on another person's plan? ☐Yes ☐No
If this is YOUR own plan, what is YOUR ID number_____Group number if available_____
If you are a dependent, what is the policy holder's NAME _____ DOB _____
Patient relationship to policy holder_____Policy holder's ID Number or Social Security #_____
Do you have a Secondary Insurance Plan? ☐Yes ☐No
For the Secondary Plan:
**Is the patient a dependent on another person's plan? ☐Yes ☐No
Please disclose the same information for the secondary plan as requested for the plan above to our team.

Whom may we thank for referring you?

☐One of our valued patients_____ ☐Yelp ☐Google ☐Our Website
☐Other_____
Please list members of your immediate family who are patients in our practice_____

☺ **Email address**_____

Preferred method of contact: ☐cell phone ☐work phone ☐email

Patient Signature_____**Date**_____