Patient Information

Patient Name: ____ Today's Date: __________________
SSN:________________________ Date of Birth: _____________________ Sex: Male [ ] Female [ ]
Address: _______________________________________ City: _________________ State: _____ Zip:_______
Home Phone: ____________________ Cell Phone: ___________________ Work Phone: ______________
E-Mail Address ____
Employer: ____ Occupation: __________________________
Spouse or Parent Name: _______________________________Contact Number: ___________________
Pharmacy Name: _______________________________________ Phone Number: _____________________
Emergency Contact: ____________________________________ Phone Number: _____________________

Dental Insurance

Insurance Company: _______________________________ Policy: _________________ Group: __________
Insurance Company Address: _______________________________ Phone Number: ________________
Policy Holder Name: ____
Policy Holder SSN: ______________________________ Policy Holder DOB:__________________________
Patient's Relationship to Insured: ____
Secondary Insurance Company: ____

Privacy Policy

Occasionally it is necessary for our office to call a patient regarding appointments, insurance, financial matters, test results, coordinate/discuss referral to another dentist, discuss medication changes, refills, etc. Please list the family members or other persons, if any, whom we may inform, discuss, or leave messages with about your medical/dental condition and your diagnosis. This is only necessary if we cannot reach you.

Name: ____
Relationship:_____________________________________
Phone Number(s)__________________________________
Name: ____
Phone: ____
Number(s) ______________________________________
May we contact you via email? [ ] Yes [ ] No May we contact you via text? [ ] Yes [ ] No

Signature: ____