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# PATIENT INFORMATION

PERSONAL INFORMATION

Today's Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ File # \_\_\_\_\_

Patient's Name \_\_\_\_\_ (\_\_\_\_\_)  
LAST FIRST MI PREFERRED OR NICK NAME

Patient's Address: Street, Apt # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Ext \_\_\_\_\_ Cell Phone # \_\_\_\_\_

E-mail \_\_\_\_\_ Marital Status:  Single  Married  Separated  Divorced  Widowed  Minor

Spouse's Name \_\_\_\_\_ Do you have children?  Yes  No How many? \_\_\_\_\_

Social Security # \_\_\_\_\_  Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MONTH / DAY / YEAR

Patient Employer/School \_\_\_\_\_ How Long? \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone # \_\_\_\_\_

Referred by:  Radio  Newspaper  Magazine  Website  Facebook  Friends or Family \_\_\_\_\_

INSURANCE

Primary Dental Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Insured's Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MONTH / DAY / YEAR

Secondary Dental Insurance Company Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Insured's Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_  
MONTH / DAY / YEAR

EMERGENCY

Emergency Contact Name \_\_\_\_\_ Relation \_\_\_\_\_

Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_ Doctor's Phone # \_\_\_\_\_