CONFIDENTIAL PATIENT INFORMATION

Patient's Name: _____
Last First Middle

Home Address: _____
Street City State Zip

Employer:_____ Occupation: _____

Work Address: _____
Street City State Zip

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

Email: _____ Birthdate: _____ Social Security No.: _____

Marital Status: _____

If patient is a minor list Parent/Responsible Party: _____

Whom may we thank for referring you to our office: _____

What time/day works best for appointments? _____

Have you seen another dentist or dental specialist within the last 12 months? ( ) Yes or ( ) No

Are you interested in cosmetic procedures such as Botox, Fillers or PDO threads? ( ) Yes or ( ) No

Are you experiencing pain? ( ) yes or ( ) No

If yes, Please Explain_____

INSURANCE INFORMATION

Policy Holder's Name: _____Social Security No.: _____

Insurance Company:_____ Insurance Co. Phone: _____

Insurance Co. Address:_____

Policy Holder's Employer: _____ Group No.:_____

Do you have dual coverage? No (__) Yes (__) If Yes:

Policy Holder's Name: _____ Social Security No.: _____

Insurance Company: _____ Insurance Co. Phone: _____

Group No.: _____ Policy Holder's Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Complete Address: _____

Home Phone: _____ Cell Phone: _____

I understand that where appropriate, credit bureau reports may be obtained. I understand that insurance coverage is only an estimation. I understand the patient (or responsible party) is responsible for any balance due for all treatment not covered by insurance.

Signature: _____ Date:_____

Parent/Guardian's signature if patient is a minor: _____Date:_____