PATIENT INFORMATION SHEET

(Office Use)
Initial
Date

Patient Name: ______________________________ **DOB:** ______________
Mailing Address: ______________________ **City:** __________ **State:** _____ **Zip:** ______
E-MAIL Address: ______________________________
Home Phone: ______________ **Work:** ______________ **Cell Phone:** ______________
Please circle: Male Female Married Single Child Other ______________
SS#: ______________________ (Due to data processing requirements SS# required)
Patient/Guardian:
Employer Name ______________________ **Address:** ______________________
Phone: ______________________ **Occupation:** ______________________
Doctor's name that you are seeing today: ______________________________

Spouse Name: ______________________ **Work Phone:** ______________________

Guardian's name and address: ______________________________________
DOB: ______________ **SS#** ______________ **Phone:** ______________
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Primary Insurance Company: ______________________________________
Address: ______________________________________
Policy Holder Name: ______________________________________
DOB: ______________________ **SS#** ______________________
Policy holders employer: ______________________________________
Member#: ______________ **Group #:** ______________ **Effective date:** __________

Secondary Insurance Company: ______________________________________
Address: ______________________________________
Policy Holder Name: ______________________________________
DOB: ______________________ **SS#** ______________________
Policy holders employer: ______________________________________
Member#: ______________ **Group #:** ______________ **Effective date:** __________

***** (If insurance is under spouse's name, please give name, DOB and SS#)*****

Emergency Contact Name: ______________________________.
(Other than spouse)
Home Phone: ______________ **Work:** ______________ **ext** __________
Relationship to patient: ______________________________________

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? Another patient/friend Another patient/relative
Dental Office Yellow Pages Newspaper School Work TV Commercial Flyer Other
Name of person or office referring you to our practice ______________________________