Patient Information Sheet

Welcome and thank you for choosing our office for your dental care! Please take a moment to completely fill out the information below, which will help us to meet your needs. If you have any questions, please do not hesitate to ask!

PATIENT INFORMATION

First Name: _____ Last Name:_____ Middle Init.:_____

Preferred Name: _____ Who is responsible for your account: _____

Address:_____ City: _____ State:_____ Zip:_____

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

Circle: Male Female Marital Status (circle): Single Married Separated Divorced Widowed

Birthdate (mm/dd/yy):_____ Social Security #:_____-_____-_____ Driver License #_____

Email Address: _____ Emer Contact/relationship: _____ Phone: _____

RESPONSIBLE PARTY – the person financially responsible for your account

First Name: _____ Last Name: _____ Middle Init.:_____

Employer: _____ Relationship to Patient: _____

Address: _____ City: _____ State:_____ Zip:_____

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

Circle: Male Female Birthdate (mm/dd/yy):_____ Social Security #:_____-_____-_____

INSURANCE INFORMATION – please provide a copy of your insurance card

Full Name of Policy Holder: _____ Relationship to Patient: _____

Address: _____

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

Birthdate: _____ Social Security #_____-_____-_____ Occupation:_____

Employer: _____ Employer Address: _____

Insurance Company:_____ Group Number:_____

FOR CHILD PATIENTS

Mother's Name: _____ Phone: _____ Employer: _____

Father's Name: _____ Phone: _____ Employer: _____