PATIENT INFORMATION SHEET

Patient's Name: ______________________________ Date: ______________

SSN: ____________ Birthdate: ________ Age: ________ Referred By: ______________

Address: ______________________________ City, State, Zip Code: ______________

Phone #: ____________ Cell Phone #: ____________ Email: ______________

Sex: Male Female Marital Status: Married Single Widow Divorced Other

Employer: ______________________ Phone: ____________ Occupation: ____________

Emergency Contact Person: ______________________ Relationship: ______________

Address: ______________________________ Phone: ______________

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

If same as above mark here: ________

Name of Responsible Person: ______________________ Relationship: ______________

Address: ______________________________ City, State, Zip Code: ______________

Phone #: ____________ Cell Phone #: ____________ SSN: ______________

Employer: ______________________________ Wk. Phone # : ______________

Employer's Address: ____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW;

PRIMARY INSURANCE (Use your Identification Card)

Insured's Name: ______________________ DOB: __________ SSN: ______________

Patient's Relationship to Insured: Self: ________ Spouse: ________ Child: ________ Other: ________

Employer: ______________________________ Phone #: ______________

Insurance Company: ______________________ ID#: __________ Group #: __________

Claims address: ____

SECONDARY INSURANCE (Use your Identification Card)

Insured's Name: ______________________ DOB: __________ SSN: ______________

Patient's Relationship to Insured: Self: ________ Spouse: ________ Child: ________ Other: ________

Employer: ______________________________ Phone #: ______________

Insurance Company: ______________________ ID# : __________ Group#: __________

Claims address: ____

(Rev. 4/05)