Patient Information Form

How did you hear about our office?

☐ Billboard/Outdoor ☐ Family/Friend/Patient ☐ Insurance Referral ☐ Internet/Google/Ads
☐ Mailings ☐ Print/Magazine ☐ Professional/DDS/MD ☐ Special Promotions
☐ Signage/Walk-In ☐ Social Media/Facebook ☐ TV ☐ Radio
☐ Website ☐ Yellow Pages ☐ Other: _____

Name _____ _____ _____ Gender _____
Last First MI

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. How do you wish to be addressed:_____

Address:_____
Mailing Address City State Zip

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

Email Address: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Responsible Party Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name: _____

Employee/Subscriber Name:_____
Last First MI

Secondary Subscriber:

Address:_____
Mailing Address City State Zip

Secondary Subscriber Social Security #: _____

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: _____ Subscriber ID #: _____

Group/Employer Name:_____ Group Number: _____

Secondary Insurance Company Name: _____

Employee/Subscriber Name:_____
Last First MI

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: _____ Subscriber ID #: _____

Group/Employer Name:_____ Group Number: _____

Thank you for choosing our practice. We appreciate your confidence in our care and services.