Patient Information

Patient Name: _____ Today's Date: _____
SSN:_____ Date of Birth: _____ Sex: Male [ ] Female [ ]
Address: _____ City: _____ State: _____ Zip:_____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
E-Mail Address _____
Employer: _____ Occupation: _____
Spouse or Parent Name: _____Contact Number: _____
Pharmacy Name: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____

Dental Insurance

Insurance Company: _____ Policy: _____ Group: _____
Insurance Company Address: _____ Phone Number: _____
Policy Holder Name: _____
Policy Holder SSN: _____ Policy Holder DOB:_____
Patient's Relationship to Insured: _____
Secondary Insurance Company: _____

Privacy Policy

Occasionally it is necessary for our office to call a patient regarding appointments, insurance, financial matters, test results, coordinate/discuss referral to another dentist, discuss medication changes, refills, etc. Please list the family members or other persons, if any, whom we may inform, discuss, or leave messages with about your medical/dental condition and your diagnosis. This is only necessary if we cannot reach you.

Name: _____
Relationship:_____
Phone Number(s)_____
Name: _____
Phone: _____
Number(s) _____
May we contact you via email? [ ] Yes [ ] No May we contact you via text? [ ] Yes [ ] No

Signature: _____