Patient Information Form

Name: _____ **Nickname:** _____ **Date:** _____
Mr. Mrs. Miss Ms. Dr.

Marital Status: Single___ Married___ Divorced___ Widowed___
Address: _____ **Suite / Lot / Apt #** _____
City: _____ **State:** _____ **Zipcode:** _____
Date of Birth: _____ **Social Security Number:** _____
Drivers License Number: _____

Home Phone: _____ **Cell Phone:** _____
Work phone: _____

Email Address: _____

In case of emergency…whom shall we contact: _____ **Relationship:** _____
Phone number/s of person: _____

How did you hear of our office? _____

Employer: _____ **Position:** _____

Dental Insurance: Primary Does not apply: ☐ **(I have no dental insurance)**

Name of Dental Insurance Company: _____ **Phone number:** _____
Group Number: _____ **Employer through whom you have insurance:** _____
Person whom carries the insurance for this patient: _____
Address of insurance company: _____
ID #/ SS# of person whom carries the insurance: _____
Birth date of the person whom carries the insurance_____

Dental Insurance: Secondary Does not apply: ☐ **(I have no secondary dental insurance)**

Name of Dental Insurance Company: _____ **Phone number:** _____
Group Number: _____ **Employer through whom you have insurance:** _____
Person whom carriers the insurance for this patient: _____
Address of insurance company: _____
ID #/ SS# of person whom carries the insurance: _____
Birth date of the person whom carries the insurance_____

I certify that the above information is accurate and correct:

Signature: _____ **Date:** _____