Patient Information Form

Today's Date___________________________

Patient Name: First_____________________________ MI_______ Last_________________________ Nickname__________

Address: Street____ City___________________ State________ Zip________

Phone: Home____ Work__________________ Mobile_________________

Email address:____

Social Security Number____ Date of Birth_____________

Driver's License#____ State__________________

Patient Employed By________________________________ Occupation___________________Phone___________________

Address: Street____ City___________________ State________ Zip________

Gender: ☐Male ☐Female ☐Trans ☐Prefer not to disclose

In case of emergency, who should be notified?____

Relationship to patient__________________________________ Emergency phone__________________________________

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Is the patient a Minor ☐ Yes ☐ No Full-time student ☐ Yes ☐ No Name of School___________________

Name of Responsible party: First_________________________ Last______________________ Date of Birth____________

If patient is a Minor, primary residency ☐Both Parents ☐Mom ☐Dad ☐Step Parent ☐Shared Custody ☐Guardian

Address (if different from patient) Street______________________ City___________________State_________Zip_______

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Dental Benefit Plan Information

Primary Dental Plan Name____ Phone_________________

Name of Insured_____________________________________ Date of Birth________________ ID number______________

Policy number____ Patient relationship to insured_________________________