PATIENT INFORMATION RECORD

DEMOGRAPHIC INFORMATION:

DATE: _____ NAME:_____

SS# : _____ GENDER: _____ DATE OF BIRTH:_____

ADDRESS: _____

Home Phone: _____ Cell Phone: _____

EMAIL: _____ EMPLOYER/SCHOOL: _____

MARITAL STATUS: _____ AGE: _____

REFERRAL INFORMATION:

Referred by (Complete all that apply):

Dentist: _____ Doctor (MD): _____

Other Referrals:

- ☐ Friend/Relative/Neighbor
- ☐ Found us on Google
- ☐ Found us on Social Media
- ☐ Other: _____

INSURANCE INFORMATION:

DO YOU HAVE DENTAL INSURANCE? (Please circle) YES NO

If yes, DENTAL Insurance Company Name: _____

ID #: _____ Group #: _____

Dental Insurance Co. Claims Address: _____

Name of Subscriber: _____ DOB of Subscriber: _____

DO YOU HAVE MEDICAL INSURANCE? (Please circle) YES NO

If YES, please circle all that apply: Private Insurance Medicare Medicaid Other

PLEASE GIVE your dental and/or medical insurances cards to our front desk staff!

PHARMACY INFORMATION:

NAME OF YOUR PHARMACY: _____

ADDRESS OF PHARMACY: _____

SIGNATURE: _____