Patient information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name_____Today's date_____

Date of birth_____Age_____ Gender_____

Social Security number_____ Driver's license number_____ State_____
Home address_____
_____
Phone_____ Cell Phone_____ Email address_____
Billing address *(if different from above)* _____
_____

Employer/occupation_____Business phone_____
Spouse's name_____Spouse's phone_____
Who is responsible for this account _____

Emergency contact and phone *(other than spouse)* _____

Primary dental insurance_____ Group number_____
Subscriber's name_____ ID number_____ Date of Birth_____
Secondary dental insurance_____ Group number _____
Subscriber's name _____ ID number _____ Date of Birth _____

Name of your medical doctor_____
Date of last visit to medical doctor_____

Name of previous dentist_____
Date of last visit to dentist_____

Referred to us by_____