

Patient Information Form

Today's Date _____

Patient Name: First _____ MI _____ Last _____ Nickname _____

Address: Street _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Mobile _____

E-mail address _____

 By Providing your e-mail address you agree to receive (check one or both) ☐ Appointment Reminders ☐ Practice Newsletter

 What is your preferred method of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ E-Mail

Social Security Number _____ Date of Birth _____

Drivers License # _____ State _____

Patient Employed By _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

 Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

In case of emergency, who should be notified? _____

Relationship to Patient _____ Home Phone _____ Mobile Phone _____

 Is the patient a Minor? ☐ Yes ☐ No Full-time Student ☐ Yes ☐ No Name of School _____

Name of Responsible Party: First _____ Last _____

 Date of Birth _____ Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other _____

 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 _____

Phone: Home _____ Work _____ Mobile _____

Employer (if different from above) _____ Occupation _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Dental Benefit Plan Information

Primary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Secondary Dental Plan Name _____ Phone _____

Address: Street _____ City _____ State _____ Zip _____

Name of Insured _____ Date of Birth _____ ID Number _____

Policy Number _____ Patient Relationship to Insured _____

Dental Office Forms Templates

Kathleen Armour



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