

## PATIENT INFORMATION FORM

Please print and complete all entries

Patient Name (Last, First Middle) Mr. Mrs. Miss. Ms.	Date of Birth	Age	(Circle One)  Single  Married	Today's Date
Address (Street, City, State, Zip)	Home Phone			
Employer and Occupation (if child, Father's Name and Employer)	Work Phone (if child, Father's)		Extension	
Employer Address (if child, Father's)	Patient's Social Security Number (if child, please <u>also</u> list father's SS#)			
Spouse Name (if child, Mother's Name) (Last, First, Middle)	Spouse (if child, Mother's) Social Security Number			
Spouse (if child, Mother's) Employer and Occupation	Spouse (if child, mother's) Date of Birth			
Spouse (if child, Mother's) Employers Address	Spouse (if child, Mother's) Work Number			
Nearest Relative Not Living With You and Address	Relationship			
	Phone Number			
In case of Emergency Contact:				
			Relationship	Phone:
Who May We Thank For Referring You To Us? (Please circle)		Family Physician:		
Patient _____ Dr. _____	Phone Number:			
Yellow Pages    Signage    Other:				
Who is Financially Responsible For This Bill?		I Will Be Paying Today By: (please circle)		
		Cash	Check	Credit Card
		The Help Card                      Other:		
Do You have Dental Insurance? (please Circle)		No	Yes	Identification #:
Name of Insurance Company:			Policy #:	
Do you have a Secondary Dental insurance Carrier?		No	Yes	Identification #:
Name of Insurance Company:			Policy #:	
It is necessary that you provide claim forms for all professional services that may be eligible for insurance coverage.				
Please present your insurance card so that we have all relevant insurance information on file.			Thank you.	