Patient Information Form **Today's Date**________________

Patient Name:____Nickname____________________
First MI Last

Address: ____
Street City State Zip

Phone: Home___________________________Work________________________Mobile_______________________

E-Mail address:____

What is your preferred method(s) of contact? ☐ Home Phone ☐ Work Phone ☐ Mobile ☐ Text ☐ E-mail

Appointment Reminders: Email: ☐ YES ☐ NO **Text:** ☐ YES ☐ NO **Call:** ☐ YES ☐ NO

Social Security Number:________________________________**Date of Birth:**_________________________________

Driver' s License #:_____________________________________**State Issued:**_______________________________

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

In case of emergency, who should be notified? ____

Relationship to Patient:________________________ Home Phone___________________ Mobile________________

Patient Employer:____**Occupation:**____________________________

Employer Address:____
Street City State Zip

Whom may we thank for referring you?:____

Please complete if patient is a minor or is not the Responsible Party

Name of Responsible Party: ____
First Last

Date of Birth:________________ **Relationship to Patient:** ☐ Spouse ☐ Parent ☐ Other____________________

Primary residency of patient: ☐ 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____________________________

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#:**______________________

Policy #:___________________________________**Patient Relationship to Insured:**____________________________

Secondary Dental Plan Name:____**Phone:**_________________________

Address: ____
Street City State Zip

Name of Insured:______________________________**Date of Birth:**_________________**ID#:**______________________

Policy #:___________________________________**Patient Relationship to Insured:**____________________________