Patient Information Card

Date _____

PLEASE PRINT

PATIENT INFORMATION

Last Name_____ First_____ Middle_____

Mailing Address_____ City_____ State_____ Zip_____ How Long?_____
(And Street if P.O. Box)

Email_____ Home Phone_____

SEX		Month Day Year	Marital Status
M	F	Date of Birth	S M W D

Occupation_____ Employer's Name_____

Employer's Address_____ Bus. Phone_____

Social Security #_____ Driver's License #_____

PARTY RESPONSIBLE

Name _____ Home Phone_____

Mailing Address_____ City_____ State_____ Zip_____
(And Street if P.O. Box)

Employer Name and Address_____

Relationship to Patient_____ Occupation_____ Bus. Phone_____

Social Security #_____ Date of Birth_____ Driver's License #_____

PAYMENTS TO BE MADE BY

Cash_____ Check_____ VISA / MC / Disc / AmEx #_____

DENTAL INSURANCE

Insured Party_____ ID# _____ Social Security #_____

Employer_____ Phone# _____ Insurance Company_____

Send Claims To _____ Phone #_____

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO INSURANCE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME

_____ _____ _____ _____

SIGNED (PATIENT, OR PARENT IF MINOR) **DATE** **SIGNED (INSURED PERSON)** **DATE**

OTHER

Previous Dentist Name_____ Physician's Name_____

Name & phone # of nearest relative not living with you_____

Is any other member of your family a patient here? If so, patient's name and phone #_____

Whom may we contact in case of emergency? _____ Phone_____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?

(Please circle)

1. Referred by a patient. Who? _____
2. Referred by a Doctor. _____
3. Website
4. Other_____