

Patient Chart # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____

Last First Middle (No initials)

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

Patient's Social Security Number: _____ - _____ - _____

Patient Employer: _____ Work Phone: _____

Sex: Male / Female Married Widowed Single Minor
Separated Divorced Partner

E-mail _____ School Attending if Student _____

Spouse or Parent's Name _____

Spouse or Parent's Employer _____ Occupation _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____

Relation to Patient _____ Birth Date _____ Home Phone _____

Address _____

Employer _____ Work Phone _____

SS # _____ Driver's License # _____

REFERRAL

Patient referred by: _____

Reason for visit: _____

Name of your Dentist: _____

Name of Physician: _____

DENTAL INSURANCE INFORMATION

Subscriber _____ Relation to Patient _____ Phone _____

Subscriber's address if different from patient's _____

Date of Birth _____ Social Security # or ID# _____

Employer _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____ Group # _____

ADDITIONAL DENTAL INSURANCE

Employed Person _____ Relation to Patient _____ Phone _____

Subscriber's address if different from patient's _____

Date of Birth _____ Social Security # or ID # _____

Employer _____ Work Phone _____

Insurance Company _____

Insurance Address _____

Insurance Phone _____ Group # _____

Signature of Insured Person or Responsible Party

Date