PATIENT INFORMATION

Please Note: All of the following information is needed to allow us to treat you safely and will be kept CONFIDENTIAL.

Patient's Last Name _____ Patient's First Name _____ MI _____

Patient's Date of Birth _____ Social Security Number

Gender
☐ Male ☐ Female

Family Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Home Phone _____ Cell Number _____ Email Address _____

Street Address _____ Apartment # _____

City _____ State _____ Zip Code _____

How did you hear about us? _____

Emergency Contact _____ Relation to Patient _____ Phone Number _____

What is the purpose of your visit today? _____

Date of Last Dental Visit _____

Do you have a toothache now?
☐ Yes ☐ No

On a scale of 0-10, with 10 being the most painful, what is your pain level today? ___

Patient Height (ft/In) _____ Patient Weight (lbs) _____

Date of last medical appointment _____ Purpose of that appointment _____

Who is your primary care provider? _____ Phone Number _____

Pharmacy Name _____

Pharmacy Address _____

Primary Dental Insurance Information

Is the patient covered under a dental insurance plan?

☐ Yes ☐ No

Subscriber's Name

_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Dependent

Subscriber's Date of Birth

_____ (mm/dd/yyyy)

Subscriber's ID / Member Number

_____

Primary Dental Insurance Provider

_____

Insurance Phone Number

_____

Employer

_____

Group Number

_____

Secondary Dental Insurance Information

Is the patient covered by a secondary dental insurance plan?

☐ Yes ☐ No

Subscriber's Name

_____

Patient's Relationship to Subscriber:

☐ Self ☐ Spouse ☐ Child ☐ Dependent

Subscriber's Date of Birth

_____ (mm/dd/yyyy)

Subscriber's ID / Member Number

_____

Secondary Dental Insurance Provider

_____

Insurance Phone Number

_____

Employer

_____

Group Number

_____

To the best of my knowledge, all the preceding answers are correct and true.

Patient/Guardian Signature

Date

_____