

# PATIENT INFORMATION

CHART # \_\_\_\_\_

### PATIENT

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Cell/Pager (\_\_\_\_) \_\_\_\_\_

E-mail \_\_\_\_\_

Social Security # \_\_\_\_\_

DL# \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

### RESPONSIBLE PARTY (If same as above, please skip)

Name \_\_\_\_\_  
Last First

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

How long at this address? \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ DL# \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_

### EMPLOYMENT

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

How Long? \_\_\_\_\_

Business Address \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

Business Phone (\_\_\_\_) \_\_\_\_\_ Ext. # \_\_\_\_\_

Verified By \_\_\_\_\_ Date \_\_\_\_\_  
(Office use only)

### REFERENCES

Name \_\_\_\_\_  
Last First

Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Spouse's Work Phone (\_\_\_\_) \_\_\_\_\_  
Last First

### PERSON TO CONTACT FOR EMERGENCY:

Last \_\_\_\_\_ First \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_

Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

### GETTING TO KNOW YOU

Do you have family members who may need dental care?  
 If so, please list name & relationship (son, daughter, husband)

1: \_\_\_\_\_ 2: \_\_\_\_\_  
 3: \_\_\_\_\_ 4: \_\_\_\_\_

How did you hear about our office? (Check one)

- |   |  |
|---|--|
| <input type="radio"/> Family-Friend (400)   | <input type="radio"/> Insurance Plan (460)       |
| <input type="radio"/> ConfiDent® (440)      | <input type="radio"/> Television (020)           |
| <input type="radio"/> Newspaper (470)       | <input type="radio"/> Radio (030)                |
| <input type="radio"/> Billboard (050)       | <input type="radio"/> Yellow Pages (120)         |
| <input type="radio"/> Flyer-Coupon (490)    | <input type="radio"/> Direct Mail-Postcard (480) |
| <input type="radio"/> Office Sign (420)     | <input type="radio"/> Internet-Website (190)     |
| <input type="radio"/> Office Transfer (430) |  |

I want information in Spanish: YES  NO

### INSURANCE / DENTAL PLAN

Primary:  Insurance  PPO  HMO (Check one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

### INSURANCE / DENTAL PLAN

Secondary:  Insurance  PPO  HMO (Check one)

Plan Name \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

Insurance / Plan Phone # \_\_\_\_\_

Employer \_\_\_\_\_

Union/Local \_\_\_\_\_ Group # \_\_\_\_\_ Plan# \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's Soc. Sec. # \_\_\_\_\_ Birthdate \_\_\_\_\_

- I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.
- By signing below, I authorize that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
- I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
- I understand that this dental practice is owned and operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist or corporate entity is responsible for my dental treatment.

Signature of Responsible Party or Patient  
 (Parent if Patient is a Minor)

Date