Confidential Patient Information – I

(Please Print Legibly)

DATE: _____

PERSONAL INFORMATION

Name: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home): _____ (Work) _____

(Cell) _____ e-mail: _____

Birth date: _____ Sex: _____ Marital Status: _____ Spouse Name: _____

Occupation: _____ Referred by: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home): _____ (Work) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

Secondary Insurance Co: _____

Insurance Co. Address: _____

Employee: _____ Relationship: _____ S.S. #: _____

Employer: _____ Policy #: _____

I understand that payment is my obligation regardless of insurance or any other third-party involvement.

SIGNATURE: _____ DATE: _____