



# 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: \_\_\_\_\_ Occupation: \_\_\_\_\_

*How did you hear about us?* \_\_\_\_\_

## **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.*

**PATIENT'S NAME**

**DATE**

\_\_\_\_\_