Personal Information Sheet

Today's Date_____Appointment Date_____Time_____
Patient's
Name_____Nickname_____DOB_____
Age:_____ M F SSN _____
Address:_____
City_____ST_____Zip_____
Billing Address (if different from above)_____
City_____ST_____Zip_____
Phone Numbers:
Home_____Work_____Cell_____Email_____
Parent/Guardian:_____
Address:_____
City_____ST_____Zip_____
Emergency Contact:_____Relationship_____Phone_____
Employer:_____Occupation:_____
Address:_____
City_____ST_____Zip_____
How did you hear about us?_____
Physician's Name:_____Phone_____
Orthodontist Name:_____Phone_____
Your Last Visit to Dentist:_____Reason_____
Reason for today's visit _____
_____
Family members who have been patients here:_____

Dental Insurance:

Subscriber Name:_____DOB_____
Subscriber SSN_____Subscriber ID_____Group #_____
Your Relationship to Insured:_____
Subscriber's Employer:_____Phone_____
Insurance Co Name:_____Phone_____
Address:_____
City_____ST_____Zip_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider who may release such information to you. I will notify the doctor of any change in my health or medication.

Signature_____DATE_____

(If minor, Parent/Guardian)