

# 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:
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