

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ (mm/dd/yyyy) Sex ___ male ___ female

Social Security No _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

Spouse Name _____ Date of Birth _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____

Employer _____ Job Title _____

Employer Address _____ City _____ State _____

Employer Phone _____

INSURANCE INFORMATION

PRIMARY

Insured/Policy Holder Name _____ Insured Date of Birth _____

Insured ID# or Social Security No _____

Insured Employer _____

Primary Insurance _____ Group No _____

Insurance Company mailing address for claims _____

City _____ State _____ Zip _____ Phone No _____

Relationship to patient _____

SECONDARY INSURANCE COMPANY

Insured/Policy Holder Name _____ Insured Date of Birth _____

Insured ID# or Social Security No _____

Insured Employer _____

Primary Insurance _____ Group No _____

Insurance Company mailing address for claims _____

City _____ State _____ Zip _____ Phone No _____

Relationship to patient _____

REASON FOR APPOINTMENT _____ **New patient (no concerns)** _____

Hot/Cold _____ **Broken tooth** _____ **Pain** _____ **Swelling** _____

Current Medications _____

Medication Allergies _____