PATIENT INTRODUCTION

TITLE:

____

LAST NAME **FIRST NAME** **MIDDLE INITIAL** **BIRTHDATE**

____

STREET ADDRESS **APT # / UNIT**

____

CITY **STATE** **ZIP CODE**

____

TELEPHONE# **ALTERNATE# (CELL, PAGER)**

____

PATIENT EMPLOYER **OCCUPATION**

____

BUSINESS ADDRESS **BUSINESS TELEPHONE**

____

PATIENT SOCIAL SECURITY NUMBER (required if primary insurance policy holder or for personal check writing)

____

NAME OF SPOUSE **BIRTHDATE**

____

SPOUSE EMPLOYER **OCCUPATION**

____

BUSINESS ADDRESS **BUSINESS TELEPHONE**

____

SPOUSE SOCIAL SECURITY NUMBER (required if spouse is a dental policy holder under which you are insured)

____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED? **TELEPHONE NUMBER**

IF PATIENT IS UNDER THE AGE OF 18, PARENT OR LEGAL GUARDIAN INFORMATION

MOTHER'S NAME ____________________________________ **MOTHER'S SS#**________________________**DOB**__________

ADDRESS ____ **HOME PHONE** _________________________

EMPLOYER ________________________**OCCUPATION**_________________ **WORK PHONE** __________________

FATHER'S NAME _______________________________________ **FATHER'S SS#** _________________________**DOB**_________

ADDRESS ____ **HOME PHONE** _________________________

EMPLOYER _________________________**OCCUPATION** _________________ **WORK PHONE** __________________

DENTAL INSURANCE INFORMATION

____

PRIMARY DENTAL INSURANCE **POLICY HOLDER'S NAME** **RELATIONSHIP TO INSURED**

____

ID / POLICY / CERTIFICATE # **PLAN NAME OR #** **GROUP #**

____

SECONDARY DENTAL INSURANCE **POLICY HOLDER'S NAME** **RELATIONSHIP TO INSURED**

____

ID / POLICY / CERTIFICATE # **PLAN NAME OR #** **GROUP #**

____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE ?