Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____

The following are the medical alerts we have on file for this patient:

List all changes to patient's medical history below:

1) _____

2) _____

3) _____

Responsible Party Information

Name: _____

KINDLY REVIEW CONTACT INFORMATION BELOW AND UPDATE AS NEEDED INCLUDING ADDITIONAL NUMBERS:

Home Phone #: _____ Work Phone #: _____

Cell Phone # (if applicable): _____ E-Mail Address***: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

We have the following insurance information on file for this patient:

Primary: _____ Secondary (if applicable): _____

Is this information correct? ☐ Yes ☐ No Please give updated information below:

New Insurance Carrier: _____ Subscriber Name: _____

Employer: _____ DOB: _____ SSN: _____

_____ Date: _____ Relationship to Patient: _____
Signature of Person Completing Form

_____
Printed Name of Person Completing Form