

# PATIENT INFORMATION FORM

PERSONAL INFORMATION (CONFIDENTIAL)					
Last Name	First Name	Middle Initial	Date of Birth	Gender	Social Security Number
Street Address			City	State	Zip
Home/Cell Phone			Email Address		Work Phone
Marital Status (please check one) <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> Under 18			Employer & Employer's Address		Occupation
Spouse's Last Name		First Name	Middle Initial	Spouse's Date of Birth	Spouse's Cell Phone
Spouse's Employer and Employer's Address					Spouse's Work Phone
Emergency Contact Name and Relationship (other than spouse)					Emergency Contact Phone
INSURANCE AND FINANCIAL INFORMATION					
Subscriber Name (Primary Insurance)			Subscriber Date of Birth	Subscriber ID Number or Social Security	
PRIMARY Insurance Carrier Name			Insurance Carrier Address		
Group Name & Number		Patient Relationship to Subscriber		Insurance Carrier Phone	
Subscriber Name (Secondary Insurance)			Subscriber Date of Birth	Subscriber ID Number or Social Security	
SECONDARY Insurance Carrier Name			Insurance Carrier Address		
Group Name & Number		Patient Relationship to Subscriber		Insurance Carrier Phone	
<b>How did you hear about us?</b>					

I consent to be a patient and agree to radiographic and clinical examination. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics, oral surgery, endodontics, fixed and removable prosthodontics, implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I agree to update this information periodically, or as needed.

I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand my treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I may be unsure about.

Signature \_\_\_\_\_

Date \_\_\_\_\_