Patient Information Form

Patient Name (Mr./Mrs./Ms.): _____ DOB: _____ SS# _____

Home Address:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Employer: _____

Primary Insurance Information:

Name of subscriber: _____ Relationship: _____

Subscriber's Employer: _____

Name of Insurance Co: _____ SS# of subscriber: _____

Phone # of Insurance Co: _____ Group #: _____ DOB of subscriber: _____

Secondary Insurance Information:

Name of Subscriber: _____ Relationship: _____

Subscriber's Employer: _____

Name of Insurance Co: _____ SS# of subscriber: _____

Phone # of Insurance Co: _____ Group #: _____ DOB of subscriber: _____

Who should we contact in case of emergency:

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name of responsible party: _____

Address: _____City ,State, Zip:_____

Phone: _____ Email Address_____

I will be paying for services by: ____ CASH ____ CHECK ____ DENTICAL

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the form. I certify this information to be true and correct to the best of my knowledge. I will notify you of any changes in my health or any changes in the above information.

Signature: _____ **Date:_____**