

## PATIENT INFORMATION FORM

First Name: \_\_\_\_\_ Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Please Circle One: Female Male                      Please Circle One: Single Married Child

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Who is financially responsible for this bill? \_\_\_\_\_

Whom may we contact in case of emergency? \_\_\_\_\_ (friend/relative)

Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Who is your medical doctor? \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### INSURANCE INFORMATION

Policy Holder Name & Date of Birth (if different than the patient):

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Member ID Number (if different than patient's social number): \_\_\_\_\_

Group number: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Dental Insurance: \_\_\_\_\_

Employer of Policy Holder: \_\_\_\_\_

How did you find out about us?

- ZocDoc
- Facebook
- Insurance Directory
- Friend or Current Patient: \_\_\_\_\_
- Other: \_\_\_\_\_

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 regarding my financial responsibilities and certify that all the information provided is true and correct to the best of my knowledge. I will notify you of any change in my health status or the above information.

Signature \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_