

# Confidential Patient Information- I

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(Please Print Legibly)

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

## PERSONAL INFORMATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_

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

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

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

(Cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Spouse Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Referred by: \_\_\_\_\_

## PERSON RESPONSIBLE FOR ACCOUNT

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

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

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

Telephone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Primary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy#: \_\_\_\_\_

Secondary Insurance Co: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy#: \_\_\_\_\_

***I understand that payment is my obligation regardless of insurance or any other third-party involvement.***

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_