

## Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart #.

FOR OFFICE USE ONLY

Patient Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

Whom may we thank for referring you to our practice?

- |  |   |
|--|---|
| <input type="checkbox"/> Another patient, (friend or relative) | <input type="checkbox"/> Work             |
| <input type="checkbox"/> Internet: Toothmansion.com            | <input type="checkbox"/> Yellow Pages     |
| <input type="checkbox"/> Other Dental Office                   | <input type="checkbox"/> Dental Insurance |
| <input type="checkbox"/> 1-800-DENTIST                         | <input type="checkbox"/> Pankey Institute |
| <input type="checkbox"/> Other (name below):                   |   |

Name of person, office, or other source referring you to our practice:

## Spouse or Responsible Party Information

The following is for:  the patient's spouse  the person responsible for payment  neither-not applicable

Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  Email Address:

Phone:     Best time to call:   
Home Work Ext Mobile

Address:    
    
City State Zip Code

## Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name:  Phone:

Address:    
    
City State Zip Code

## Primary Insurance Information

### Primary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

## Secondary Insurance Information

### Secondary Dental Insurance:

Name of Insured:     
Last First MI

Insured's Birth Date:  ID #:  Group #:

Insured's Address:    
    
City State Zip Code

Insured's Employer Name:

Employer Address:    
    
City State Zip Code

Patient's relationship to insured:  Self  Spouse  Child  Other

Insurance Plan Name:

Insurance Address:    
    
City State Zip Code

