

# Patient Information Sheet

Chart # \_\_\_\_\_ Office Location \_\_\_\_\_ Date \_\_\_\_\_

## Patient Information

First Name: \_\_\_\_\_ Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone Number: ( ) \_\_\_\_\_ Home Phone Number: ( ) \_\_\_\_\_  
DL # \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: (M) (F)  
Employer: \_\_\_\_\_ Position: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ Employer Phone #: ( ) \_\_\_\_\_  
In Case of Emergency, contact: (name) \_\_\_\_\_ Phone Number: ( ) \_\_\_\_\_  
How do you intend to pay?  Cash  Credit  Insurance  Medi-Cal  Other \_\_\_\_\_

## Responsible Party

(Disregard if same as above)

First Name: \_\_\_\_\_ Int. \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone Number: ( ) \_\_\_\_\_  
DL # \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex: (M) (F)  
Employer: \_\_\_\_\_ Position: \_\_\_\_\_ How Long: \_\_\_\_\_  
Work Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Work Phone Number: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_ Department: \_\_\_\_\_

## Primary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured Address: \_\_\_\_\_  
Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer Name & Phone Number \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
Is policy connected with your Union?  Yes  No Name of Union \_\_\_\_\_ Local Union # \_\_\_\_\_

## Secondary Insurance Information

Insured First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insured Address: \_\_\_\_\_  
Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Employer Name & Phone Number \_\_\_\_\_ Insurance Company: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_ Effective Date \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Phone Number of Insurance Co.: ( ) \_\_\_\_\_  
Is policy connected with your Union?  Yes  No Name of Union \_\_\_\_\_ Local Union # \_\_\_\_\_

## Personal References

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Int. \_\_\_\_\_  
Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Int. \_\_\_\_\_  
Home Phone Number: ( ) \_\_\_\_\_ Home Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I request that all dental benefits, if any, otherwise payable to me for services rendered to be paid to the provider of service. I understand that I am financially responsible for all charges if insurance proceeds are insufficient to cover my obligations and/or a procedure, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services. I am aware that by signing below I certify that all information is complete and correct. This dental office, may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for this dental office, to verify credit history.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Signature of Responsible Party