Confidential Patient Information

Patient Name: ____ Date: __________________

Last First MI dd/mm/yyyy

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other Date of Birth: __________________

Address: ____

Apartment # and Street City Postal Code

Email address: ____

Home Phone: ______________________________ Mobile Phone: _____________________________

Emergency Contact Information

Name of Contact: __________________________________ Relationship: ______________________

Home Phone: ______________________________ Mobile Phone: _____________________________

Confidential Communication

As my dental provider you may do the following with my permission:

yes	no		yes	no	
☐	☐	Contact me at home	☐	☐	Leave messages on home voicemail
☐	☐	Contact me via mobile phone	☐	☐	Leave messages on mobile voicemail
☐	☐	Contact me at work	☐	☐	Leave messages on work voicemail
☐	☐	Contact me via email			

Insurance Information

Primary Insurance Plan Name: ____

Name of Insured:_____________________________________ Is Insured a Patient? ☐Yes ☐ No

Insured Birth Date:_____________________ ID#___________________ Group #_______________

Annual Deductible:_________ Yearly Limit:_________ Percentage Coverage: A______% B______% C_____%

Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Secondary Insurance Plan Name: ____

Name of Insured:_____________________________________ Is Insured a Patient? ☐Yes ☐ No

Insured Birth Date:_____________________ ID#___________________ Group #_______________

Annual Deductible:_________ Yearly Limit:_________ Percentage Coverage: A______% B______% C_____%

Patient Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other