CONFIDENTIAL PATIENT INFORMATION

Welcome to the practice. We appreciate the confidence you place with us to provide dental services.The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____ **Sex:** ____

Marital Status (*circle one*): **Minor / Single / Married / Divorced / Widowed / Separated**

Address:_____ **City:**_____ **State:**_____

Zip:_____

Mobile: _____ **OK to Text?**___ **Home Phone:** _____

Email: _____ **SSN:** _____

Driver's License:_____ **Employer:**_____

Bus. Phone: _____

Emergency Contact & Phone:_____

Referred by: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____

Subscriber Name: _____ **Date of birth:**_____

Subscriber SSN #: _____

Subscriber ID: _____ **Group #:** _____

Medi-cal Patients ONLY ***(Information from front of the card)***

ID: _____

Date of Birth: _____ **Issue Date:** _____