

# Confidential Patient Information – I

---

*(Please Print Legibly)*

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

## Personal Information

Name: \_\_\_\_\_ SS #: \_\_\_\_\_

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: \_\_\_\_\_ SS #: \_\_\_\_\_

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

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

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

## Dental Insurance Information

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

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

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

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

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

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

Employee: \_\_\_\_\_ Relationship: \_\_\_\_\_ S.S. #: \_\_\_\_\_

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

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

---

PATIENT'S NAME

DATE