

Patient Information Sheet

Chart # _____ Office Location _____ Date _____

PATIENT

Last Name: _____ First Name: _____ Int. _____
Home Phone Number: () _____
Home Address: _____ Apt # _____
City: _____ State: _____ Zip: _____
Social Security #: _____ DL # _____ Date of Birth: _____ Sex: (M) (F)
How did you hear about us? _____

RESPONSIBLE PARTY

Last Name: _____ First Name: _____ Int. _____
Home Address: _____ Apt # _____
City: _____ State: _____ Zip: _____ Home Phone Number: () _____
Social Security #: _____ DL # _____
Employer: _____
Position: _____ How Long: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Work Phone Number: () _____ Ext. _____
Insurance Carrier: _____
Policy Number: _____ Plan Number: _____

CREDIT REFERENCES

Credit Card Name: _____ Account Number: _____
Bank Name: _____ Account Number: _____

PERSONAL REFERENCES

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

I am aware that by signing below I certify that all information is complete and correct. This information may be verified from which ever sources are deemed necessary (including but not limited to credit reports) and may provide others with information regarding your credit history (or the credit report) to the extent permitted by law. This is your authorization to verify credit history.

Signature of Patient

Signature of Responsible Party

TO BE COMPLETED BY DENTAL OFFICE

COVERAGE: _____ DENTI-CAL: _____ INSURANCE: _____ CASH: _____ PREPAID: _____
Pre Paid Plan or Insurance Carrier: _____ Plan # or Policy #: _____
Phone #: () _____ Coverage or Liability Verified by _____
Employment Verified By: _____ Approved By: _____ Date: _____