JohnWHITEDDS

Fellow of Academy of General Dentistry • Fellow of Academy of Dentistry International

Patient Information

Welcome to our practice! Please take a moment to enter or update your information to help us provide you with the best dental care possible.

Title: *(Mr./Mrs./Ms./Dr./etc.)* ___________ Today's Date: _____/_____/_____

Last Name: ________________________________ First Name: _____________________ M.I.: _____

Preferred Name: _____________________ Email: ________________________________

Date of Birth: _____/_____/_____ Current Occupation: _____________________

Family Status: ☐ Single ☐ Married ☐ Child ☐ Other__________ Gender: ☐ Female ☐ Male ☐ Other__________

Home Address: ________________________________, ________________________________

City: ________________________________ State: _____ Zip Code: ___________

Home Phone: (_____) _____-___________ Work Phone: (_____) _____-___________Ext._____

Mobile Phone: (_____) _____-___________ Best time to call: _____________________

Party Responsible for Payment

Who will be responsible for payment? ☐ Patient *(leave this section blank)* ☐ Other Party

Title: *(Mr./Mrs./Ms./Dr./etc.)* ___________ Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other__________

Last Name: ________________________________ First Name: _____________________ M.I.: _____

Email: ________________________________ Date of Birth: _____/_____/_____

Family Status: ☐ Single ☐ Married ☐ Other__________

Home Address: ________________________________, ________________________________

City: ________________________________ State: _____ Zip Code: ___________

Home Phone: (_____) _____-___________ Work Phone: (_____) _____-___________Ext._____

Mobile Phone: (_____) _____-___________ Best time to call: _____________________

Referring Information

How did you hear about our practice and whom may we thank for referring you to us?

☐ Internet Search ☐ Yellow Pages ☐ Newspaper ☐ Another dental office ☐ School

☐ Work ☐ Person/Other: ________________________________

Primary Dental Insurance Information

Insured's Title: *(Mr./Mrs./Ms./Dr./etc.)* __________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other__________

Insured's Last Name: _________________________________ First Name: ______________________ M.I.: _____

Insured's Date of Birth: _____/_____/_____

Insured's Home Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

Insured's Employer Name: _________________________________ Current Occupation: ______________________

Insured's Employer Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

Policy Group Number: ________________ Insured's I.D. Number: _______________

Insurance Plan Name: _________________________________

Insurance Plan Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

Secondary Dental Insurance Information

Insured's Title: *(Mr./Mrs./Ms./Dr./etc.)* __________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other__________

Insured's Last Name: _________________________________ First Name: ______________________ M.I.: _____

Insured's Date of Birth: _____/_____/_____

Insured's Home Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

Insured's Employer Name: _________________________________ Current Occupation: ______________________

Insured's Employer Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

Policy Group Number: ________________ Insured's I.D. Number: _______________

Insurance Plan Name: _________________________________

Insurance Plan Address: _________________________________, _________________________________

City: _________________________________ State: _____ Zip Code: ___________

I acknowledge that I have answered these questions accurately and truthfully to the best of my knowledge. I agree to report any change of this information to this practice at the earliest possible time.

Signature of patient, or parent, or guardian (responsible party): ____

Print Name: ______________________________ Relationship to the patient: _________________ Date:_____/_____/_____