JohnWHITEDDS

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

Patient Information

INSTRUCTIONS: *If hand writing, please fill out in **black** pen ink only.*

Your Information

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

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

Preferred Name: _____ Email: _____

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

Employer Name: _____

Employer Address: _____, _____

City: _____ State: _____ Zip Code: _____

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: _____/_____/_____

Employer Name: _____

Employer Address: _____, _____

City: _____ State: _____ Zip Code: _____

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: _____

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 Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Title: *(Mr./Mrs./Ms./Dr./etc.)* _____

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: _____

Insured's Employer Address: _____, _____

City: _____ State: _____ Zip Code: _____

Insurance Plan Name: _____ Policy Group Number: _____

Insured's I.D. Number: _____

Claim Mailing Address: _____, _____

City: _____ State: _____ Zip Code: _____

Plan Phone Number for Providers: (_____) _____-_____Ext._____

Secondary Dental Insurance Information

Insured's Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insured's Title: *(Mr./Mrs./Ms./Dr./etc.)* _____

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: _____

Insured's Employer Address: _____, _____

City: _____ State: _____ Zip Code: _____

Insurance Plan Name: _____ Policy Group Number: _____

Insured's I.D. Number: _____

Claim Mailing Address: _____, _____

City: _____ State: _____ Zip Code: _____

Plan Phone Number for Providers: (_____) _____-_____Ext._____

I hereby 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:_____/_____/_____