PATIENT INFORMATION FORM

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Diplomate of American Board of Periodontology

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Name: Dr. /Mr. /Mrs. /Ms. ____
(Circle One) **First** **Middle** **Last**

Address: ______________________________

City:______________ State: ______ Zip: ________

DOB: _____/______/________ Age: ___________

Social Security #: ________-_______-___________

Employer: ______________________________

Occupation: ______________________________

Cell Phone: (_____) ________-__________

Home Phone: (_____) ________-__________

Work Phone: (_____) ________-__________

Email:____________________@_______________

Preferred contact method:
☐ Text ☐ Cell ☐ Home ☐ Work ☐ Email

May we leave you a voicemail? ☐ YES ☐ NO

Referral Information

Who referred you to our office?________________________ Name of General Dentist: ________________________

Is another family member or relative a patient at our office? **YES** **NO** Name: ________________________

Person Financially Responsible for Account

Name:______________________________________ Relationship to Patient: ________________________

Address: ____

Dental Insurance

Do you have Dental Benefits? (Circle One) **YES** **NO** *If yes, please provide card to be copied.*

Primary Insurance Company: ____________________

Employer:______________________________

Employee's Name: ________________________

Employee DOB:________/________/___________

Social Security #:_________-________-__________

Member ID #: ____________________________

Secondary Insurance Company: ____________________

Employer:______________________________

Employee's Name: ________________________

Employee DOB:________/________/___________

Social Security #:__________-_________-__________

Member ID#: ______________________________

Please list authorized persons with whom we may discuss your Protected Health Information (PHI). Please notify us if you desire to remove a name from this list in the future.

1. ______________________ Relationship:________________ Phone: ______________

2. ______________________ Relationship:________________ Phone: ______________

Patient Signature: ______________________________ **Date:** ______/______/________

Print Name: ______________________________