date

PATIENT INFORMATION FORM

1 Patient Information

If an adult, there is no need to complete sections 2 & 3

first name	middle name	last name	nickname	date of birth	age

mailing address: street	city	state	zip code

social security #	home phone #	cell phone #	Email

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced school Grade

employer	position/title	work phone #	years employed

spouse's first name	middle name	last name	social security #	date of birth

spouse's employer	position/title	work phone #	years employed

members of family that are previous patients	If patient is a child, name/age of other siblings that are not patients

2 Responsible/Billing Party: Mother's Information

If a divorce situation, please complete entire section

mother's first name	middle name	last name	social security #	date of birth

mailing address: street (if different from patient)	city	state	zip code

home phone #	cell phone #	Email

employer	position/title	work phone #	years employed

spouse's first name	middle name	last name	social security #	date of birth

spouse's employer	position/title	work phone #	years employed

3 Responsible/Billing Party: Father's Information

If a divorce situation, please complete entire section

father's first name	middle name	last name	social security #	date of birth

mailing address: street (if different from patient)	City	state	zip code

home phone #	cell phone #	Email

employer	position/title	work phone #	years employed

spouse's first name	middle name	last name	social security #	date of birth

spouse's employer	position/title	work phone #	years employed

4 Referral Information

patient's dentist	last cleaning date	Current work to be completed? ☐ YES ☐ NO

Referred by dentist? ☐ YES ☐ NO

Dentist's concerns: ☐ Crowding ☐ Spacing ☐ Bite Relationship ☐ Other _____

Other means of referral? ☐ YES ☐ NO

How? ☐ Facebook ☐ Web Search ☐ Phonebook ☐ Power 88 ☐ Friend ☐ Other _____

If a friend referred you, please give us their name so we may thank them!