

# Patient Information Form

First Name: \_\_\_\_\_ Preferred to be called: \_\_\_\_\_ M.I. \_\_\_\_\_

Last Name: \_\_\_\_\_ Home Number: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

DOB: \_\_\_\_\_ SS #: \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Employer: \_\_\_\_\_

Work Number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

We will notify patients of upcoming appointment through text message and/or e-mail.

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Single \_\_\_\_\_

(If patient is a minor) Parent Name: \_\_\_\_\_

Parent DOB: \_\_\_\_\_ Parent SS #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Person to contact in an emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Dental Benefits

Do you have dental coverage? \_\_\_\_\_ If you have a dental card, please present it at your visit.

Subscriber's name: \_\_\_\_\_ DOB: \_\_\_\_\_

Social security number: \_\_\_\_\_ Group number: \_\_\_\_\_

Employer: \_\_\_\_\_

If you do not have dental benefits we ask that payment be made in full the day of service.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above information. I will notify you of any changes in my status or the above information. Please see Restoration Dental's financial policy included in patient information.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Parent or Guardian (if minor) Date