Patient Information Sheet

Chart # _____ **Office Location** _____ **Date** _____

Patient Information

First Name: _____ Int. _____ Last Name: _____ Date of Birth: ____/____/____

Home Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Work Phone Number: ( ) _____ Home Phone Number: ( ) _____

DL # _____ Social Security #: _____-_____-_____ Sex: (M) (F)

Employer: _____ Position: _____

Employer Address: _____ Employer Phone #: ( ) _____

In Case of Emergency, contact: (name) _____ Phone Number: ( ) _____

How do you intend to pay? ☐ Cash ☐ Credit ☐ Insurance ☐ Medi-Cal ☐ Other _____

Responsible Party

(Disregard if same as above)

First Name: _____ Int. _____ Last Name: _____ Date of Birth: ____/____/____

Home Address: _____ Apt # _____ City: _____ State: _____ Zip: _____

Home Phone Number: ( ) _____

DL # _____ Social Security #: _____-_____-_____ Sex: (M) (F)

Employer: _____ Position: _____ How Long: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Work Phone Number: ( ) _____ Ext. _____ Department: _____

Primary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Insured Address: _____

Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: _____-_____-_____

Employer Name & Phone Number _____ Insurance Company: _____

Insurance Co. Address: _____ Effective Date _____

Group #: _____ Policy #: _____ Phone Number of Insurance Co.: ( ) _____

Is policy connected with your Union? ☐ Yes ☐ No Name of Union _____ Local Union # _____

Secondary Insurance Information

Insured First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Insured Address: _____

Patient's relationship to Insured (Circle): Self Spouse Child Parent Sex: (M) (F) Insured's Social Security Number: _____-_____-_____

Employer Name & Phone Number _____ Insurance Company: _____

Insurance Co. Address: _____ Effective Date _____

Group #: _____ Policy #: _____ Phone Number of Insurance Co.: ( ) _____

Is policy connected with your Union? ☐ Yes ☐ No Name of Union _____ Local Union # _____

Personal References

First Name: _____ Last Name: _____ Int. _____

Home Phone Number: ( ) _____ Home Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

First Name: _____ Last Name: _____ Int. _____

Home Phone Number: ( ) _____ Home Address: _____ Apt # _____

City: _____ State: _____ Zip: _____

I request that all dental benefits, if any, otherwise payable to me for services rendered to be paid to the provider of service. I understand that I am financially responsible for all charges if insurance proceeds are insufficient to cover my obligations and/or a procedure, I am liable for the shortfall. I authorize the provider of service to release all information necessary to secure the payment of benefits. I also consent to the examination and/or treatment of myself and all minor children listed by doctors, doctors' assistants and other medical personnel. Failure to provide complete information may result in my receiving a bill for services.
I am aware that by signing below I certify that all information is complete and correct. This dental office, may verify this information from whichever sources it deems necessary (including, but not limited to, credit reports) and may provide others with information regarding my credit history (or the credit report) to the extent permitted by law. This is my authorization for this dental office, to verify credit history.

_____ Signature of Patient

_____ Signature of Responsible Party

Form 040A (Rev. 04/01)

VRU Code: _____ Date: _____ Signature of Employee: _____