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Diplomate of American Board of Periodontology

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PATIENT INFORMATION FORM

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

Address: _____ Cell Phone: (____) _____ - _____ **Text**: ☐

City: _____ State: _____ Zip: _____ Home Phone: (____) _____ - _____

DOB: ____/____/____ Age: _____ Work Phone: (____) _____ - _____

Social Security #: _____ - _____ - _____ Email: _____ @ _____

Employer: _____ Preferred contact method: ☐Cell ☐Home ☐Work

Occupation: _____ 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: _____ Secondary Insurance Company: _____

Employer: _____ Employer: _____

Employee's Name: _____ Employee's Name: _____

Employee DOB: _____/_____/_____ Employee DOB: _____/_____/_____

Social Security #: _____ - _____ - _____ Social Security #: _____ - _____ - _____

Member ID #: _____ 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: _____ Date____/____/_____ added / removed

2. _____ Relationship: _____ Date____/____/_____ added / removed

Patient Signature: _____ **Date:** _____/_____/_____

Print Name: _____