Patient Information Form

Date _____

Name _____/_____
First Middle Initial Last Preferred Name

Address _____ City _____State _____ Zip _____

Check Box for Best # to call: Home #_____ Cell #_____ Work #_____Ext_____

Birthdate_____/_____/_____ Soc. Security # _____

Email _____

To receive Text Messages and Email regarding your appointment please visit us online at *4statesdentalcare.com* "Patient Login"

Check Appropriate Box Minor Single Married Divorced Widowed Separated

Spouse or parent's name _____ Contact Phone_____

Person to contact in case of an emergency _____ Phone _____

Relationship to patient:_____

Referral Information

Can we thank someone for referring you?

Family Member_____

Coworker_____

Friend_____

Doctor_____

Or did you find us on your own?

___Our Website
___Yellow Pages
___Lumineer or Invisalign Referral
___Insurance Company
___Location
___Letter in Mail
___Other_____

Responsible Party

Check if same as patient

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home phone _____

Driver's license # _____ Birth Date _____ Soc. Security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office Yes No

Insurance Information

Name of insured _____ Relationship to patient _____

Birthdate _____ Soc. Security # _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____

Grp. # _____ Policy/I.D.# _____