Patient Information Questionnaire
Date ____-____-____

Please complete *all* of the applicable information below. All information will be kept confidential.

Patient Information

Name: ____
Title (Mr. Mrs. Miss etc) First MI Last Nickname

Address: ____
Street City State Zip

Phone: (____) _______-_________ (_____)_______-___________ _____ (_____) ______-_________
Home Work Ext Cell

Date of Birth: ______-______-______ Social Security Number: _______-______-_______

Email Address: _________________________ ☐ I accept electronic communication from the office
(i.e. appointment reminders, special notifications etc…)

Employer Information

Employer Name: ____

Employer Address: ____
Street City State Zip

Responsible Party Information

Please complete if someone other than the patient will be responsible for this account.

Relationship to Patient: Father Mother Guardian Power of Attorney

Name: ____
Title (Mr. Mrs. Miss etc) First MI Last

Address: ____
Street City State Zip

Phone: (_____)______-___________ (_____)______-__________ ___________
Home Work Ext.

Date of Birth: ______-______-_______ Social Security Number: _______-______-_______

Employer Information

Employer Name: ____

Employer Address: ____
Street City State Zip

Referral Information

Who referred you to our office? Dentist ☐ Dentist Name __________________ Friend ☐ Self ☐ Other ☐

Financial Information

How will you be paying for your portion of today's visit? ☐ Cash ☐ Check ☐ Credit Card

I am interested in financing options for future appointments. ☐ Yes ☐ No

Emergency Contact Information

_________________________ _______________ _______________ _______________
Emergency Contact Name & Relationship Home Number Work Number Cell Number

Dental Insurance Information

Primary Dental Insurance Company Name: ____

Group / Employer Name: ____________________________ Subscriber ID Number: __________

Group Number: ________________________________ Phone: (_____)______-_____________

Insured Name: ____ Relationship: ______________
First MI Last

Insured SSN: ______-_____-______ Insured Date of Birth: _______-______-_______

Secondary Dental Insurance Company Name: ____

Group / Employer Name: ____________________________ Subscriber ID Number: __________

Group Number: ________________________________ Phone: (_____)______-_____________

Insured Name: ____ Relationship: ______________
First MI Last

Insured SSN: ______-_____-______ Insured Date of Birth: _______-______-_______

Patient's Student Status (if a dependant 18yrs or older): ☐ Full time ☐ Part time ☐ Does not apply

School Name: _____________________ ***School Address:*** ____

Medical Insurance Information

Primary Medical Insurance Company Name: ____

Group / Employer Name: _________________________ Subscriber ID Number: _____________

Group Number: ________________________________ Phone: (_____)______-____________

Insured Name: ____ Relationship: _____________
First MI Last

Insured SSN: ______-_____-______ Insured Date of Birth: _______-______-_______

Secondary Medical Insurance Company Name: ____

Group / Employer Name: ____________________________ Subscriber ID Number: __________

Group Number: ________________________________ Phone: (_____)______-_____________

Insured Name: ____ Relationship: ______________
First MI Last

Insured SSN: ______-_____-______ Insured Date of Birth: _______-______-_______

Signature of Responsible Party

I understand the information I provide on this form is part of my patient record and that the information will only be used in relation to my treatment in this office. I understand that if any change occurs, I will report it to the office as soon as possible. I have read and understand these questions and answered them all truthfully and to the best of my ability.

____ _______________

Signature of: ☐ Patient ☐ Father ☐ Mother ☐ Guardian ☐ Power of Attorney Date