Patient Information Sheet

Office: _____

Patient Information

Language: ☐English ☐Spanish Gender: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Divorce ☐Widowed ☐Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Preferred method of communication

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

Responsible Party

Relationship to patient: ☐Self ☐Guardian/Parent ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Employer Information

Employment Status: ☐Employed ☐Student ☐Retired ☐Unemployed

Employer/School Name: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: How long? Year(s) Month(s)

Emergency Contact

Relationship to patient: ☐Responsible Party ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Physician Name Phone #:

Patient Name: _____

Chart # _____ **Date:** _____

Primary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

Secondary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

How did you hear about us?

☐ 1-800-Dentist ☐ Flyer/Ad ☐ Insurance /Plan Referral: _____

☐ Sign/Building ☐ Marketing Representative: _____

☐ Yellow Pages ☐ Employer ☐ DDS Referral: _____

☐ Family/Friend ☐ Website ☐ Other _____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.

_____ _____

Signature of Responsible Party Date

(Parent or Legal Guardian if patient is a minor)

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comments

West Coast Dental Services, Inc.