Patient Information (Confidential)

Name: ______________________________ Date: ______________

Address: ______________________ City: ____________ Postal Code: ______

Phone #: Home: ____________ Cell: ____________ Work: ______________

Employer: ______________________________ S.I.N.: ______________

Would you like confirmation by Email or Text. Please circle.

Email Address: ____

Date of Birth: Day: _____ Month: _____ Year: _____ Age: _____ Sex: ☐ M ☐ F

Marital Status: ______________ Is any immediate family a patient in this office: ☐ Yes ☐ No

How did you hear about our office? ☐ Phonebook ☐ Website ☐ Other ______________

Whom may we thank for referring you? ______________________________

Spouse or Parent's Name: ______________________________________

Person to contact in case of emergency: ____________________ Phone: ____________

Insurance Information:

Insurance Company: ____

Name of Insured: ________________ Name of Policyholder/Employer: ________________

Policy or Group #: ____________ Certificate/I.D. #: ________ Date of Birth: ____________

Student: Name of School: ________________________ Student I.D. #: ____________

Plan Maximum: __________________________ Coverage Year End: ____________

Do you have a Secondary Insurance Policy:

Insurance Company: ____

Name of Insured: ________________ Name of Policyholder/Employer: ________________

Policy or Group #: ____________ Certificate/I.D. #: ________ Date of Birth: ____________

Plan Maximum: __________________________ Coverage Year End: ____________

NOTE: Payment is due on day of procedures. We will be happy to submit to your insurance for you!

Signature of Patient or Parent if Minor: ______________________________

PATIENT INFORMATION