

Patient Intake Form

Today's date: _____ E-mail address _____

Name: _____ Birthdate: ___/___/___ Age _____

Home address: _____

_____ Social Security#(for insurance) _____

Home Phone: () _____ Cell () _____ Work () _____

Best times to reach you _____ Whom may we thank for referring you? _____

Other family members that are seen by us? _____

Employer _____ Occupation _____ Years employed here _____

Employer's address _____

Neighbor or relative not living with you

Name: _____ Relation: _____ Home # _____

Address: _____ Cell # _____

Spouse Information

Name: _____ Birthdate: ___/___/___ Social Security # _____

Employer: _____ Work # _____ Ext: _____

Insurance Information

Do you have dental insurance? Yes No Insurance Co. name: _____

Insurance Co. address: _____

Insured's name: _____ Insured's Social Security #: _____

Insured's Birthdate ___/___/___ Relation to insured Party _____

Insured's Employer: _____ Insured's Address: _____