

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.# _____