# GENERAL PATIENT INFORMATION

Advanced SEDATION DENTISTRY

## PATIENT INFORMATION

Legal Name

Preferred Name

SSN#

DOB ____ / ____ / _____

Gender
- Male
- Female

Marital Status
- Single
- Married
- Other _____

### PATIENT CONTACT INFORMATION

Street Apt#

City State Zip

Home Phone Work Phone

Cell Phone Email

### PATIENT EMPLOYER INFORMATION

Employer's Name

Occupation

Work Phone Ext.

Street Ste#

City State Zip

## RESPONSIBLE PARTY INFORMATION

Legal Name

Gender
- Male
- Female

Marital Status
- Single
- Married
- Other _____

SSN#

DOB ____ / ____ / _____

Street Apt#

City State Zip

Home Phone Work Phone

Cell Phone Email

### IN CASE OF AN EMERGENCY, WHOM SHALL WE CALL?

Name

Home Phone Work Phone

Relationship to Patient

Cell Phone Email

## INSURANCE INFORMATION

### PRIMARY INSURED PERSONS INFORMATION

Legal Name

Street Apt#

City State Zip

SSN#

DOB ____ / ____ / _____

Relationship to Patient

Employer's Name Group #

Street Ste#

City State Zip

Insurance Plan Name

Member ID#

Insurance Phone Number

### SECONDARY INSURED PERSONS INFORMATION

Legal Name

Street Apt#

City State Zip

SSN#

DOB ____ / ____ / _____

Relationship to Patient

Employer's Name Group #

Street Ste#

City State Zip

Insurance Plan Name

Member ID#

Insurance Phone Number

**To whom may we thank for referring you to our practice?**

Patient (or Parent) Printed Name

Signature`

Date

**Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.**