PATIENT CONTACT INFORMATION

LAST NAME:____________________________________FIRST NAME:____________________________MIDDLE INTL____

NICKNAME:____________________________________ SALUTATION (*Circle one*): DR. / MR. / MRS. / MS.

SOCIAL SECURITY NO: _________-__________-___________ DOB:________/________/________ AGE: _______________

HOMEADDRESS:____CITY/STATE/ZIP:__________________________

CELL PHONE: _______________________ HOME PHONE:_____________________ WORK PHONE: ___________________

EMPLOYMENT STATUS (*Circle one*): FT / PT / RET EMPLOYER: ____

E-MAIL ADDRESS____

EMERGENCY CONTACT: ____________________________RELATIONSHIP:___________________PHONE: ____________

SUPPLEMENTAL INFORMATION

HOW DID YOUR HEAR ABOUT OUR OFFICE? ____

WHO ACCOMPANIED YOU TO THIS OFFICE?________________________RELATION TO PATIENT?__________________

NAME AND ADDRESS OF FAMILY PHYSICIAN: ____

NAME AND ADDRESS OF FAMILY DENTIST: ____

PREFERRED PHARMACY:____ CITY:___________________________________

CROSSROADS:____ PHONE: ______________________

INSURANCE INFORMATION

DENTAL INSURANCE CO: ____ GROUP NO: ______________________________

SUBSCRIBER'S NAME:____DOB:_____/______/______

SUBSCRIBER'S SSN or ID #: _______________________________REALTIONSHIP TO PATIENT: ________________________

EMPLOYER: ____

MEDICAL INSURANCE CO: _______________________________________ GROUP NO: ______________________________

SUBSCRIBER'S NAME:____DOB:_____/______/______

SUBSCRIBER'S SSN or ID #: _______________________________REALTIONSHIP TO PATIENT: ________________________

EMPLOYER: ____

By signing below I acknowledge that, to the best of my knowledge, the above information is truthful and accurate and if there are any changes to the above information it is my responsibility to inform the staff at iCare Oral Surgery.

PATIENT, PARENT OR LEGAL GUARDIAN:____DATE:_____/____/____