Patient Information Form Today's Date: ________________

Patient Name: First ______________________MI____ Last __________________________ Nickname _____________

Address: _____________________________________ **City**: ____________________ **State**: ________ **Zip**: __________

Phone: Home ___________________________Cell ___________________________ Work________________________

E-mail address ____

I agree to receive electronic communications. ________ (Initial)

What is you preferred method of contact? Home phone Cell Phone Work Phone E-Mail Text

Social Security # ___________________________ **Date of Birth** _____________________________ **Age** ___________

Preferred Sex: Male Female Non Bi **Marital Status:** Married Single Divorced Separated Widowed

Emergency contact __________________________ **Relationship** ___________________**Phone**___________________

Name of Responsible Party: First ___________________________________ Last _______________________________

Date of Birth _______________________ **Relationship** Self Spouse Parent Other __________________

Address (if different) ___________________________ City __________________ State __________ Zip ____________

Phone: Home ________________________ Work ___________________________ Cell _________________________

Is the patient a minor? Yes No **Full-Time Student?** Yes No College Name _______________________________

Dental Benefit Information

Dental Ins Co Name ___________________________Employer______________________ **Phone** __________________

Address ______________________________ City ___________________ State ________________ Zip _____________

Subscriber Name ____________________________ **Date of Birth** ____________________ **ID #** ___________________

Relationship to insured _____________________________________ **Group / Policy #** ___________________________

Secondary Ins Co Name ___________________________ Employer__________________ **Phone**___________________

Address ______________________________ City ___________________ State ________________ Zip _____________

Subscriber Name ____________________________ **Date of Birth** ____________________ ID # ___________________

Relationship to insured ______________________________________ **Group / Policy #** _________________________

Whom may we thank for referring you?

Name: _________________________________ Ins Co Website Walk by Google / Yelp Other __________

I give my consent to Woodstock Dental to perform diagnostic examinations, x-rays, use of anesthesia, and treatment as needed. _______ (Initial)

I acknowledge I am responsible for all charges regardless of insurance. ________ (Initial)

Signature: ____ Date:_____________________________