Patient Information Sheet

Office: _____

Patient Information

Language: ☐English ☐Spanish Gender: ☐Female ☐Male

Marital Status: ☐Single ☐Married ☐Divorce ☐Widowed ☐Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Preferred method of communication

☐ Home Phone ☐ Work Phone ☐ Mobile Phone ☐ Email

Responsible Party

Relationship to patient: ☐Self ☐Guardian/Parent ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Home #: _____ Work #: _____

Cell #: _____ Texting OK? ☐Yes ☐No

E-Mail Address: _____

Employer Information

Employment Status: ☐Employed ☐Student ☐Retired ☐Unemployed

Employer/School Name: _____

Occupation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ How long? Year(s) Month(s)

Emergency Contact

Relationship to patient: ☐Responsible Party ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Physician Name _____ Phone #: _____

Patient Name: _____

Chart # _____ **Date:** _____

Primary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

Secondary Insurance Information

Insurance Type: ☐No Insurance ☐HMO ☐PPO/Indemnity ☐Denti-Cal

Plan Name: _____

Address: _____

City: _____ State: Zip: _____

Phone #: _____

Insurance ID # _____ Policy # /Group # _____

Subscriber's Information (Primary Member)

Relationship to patient: ☐Self ☐Responsible Party ☐Spouse ☐Other

Gender: ☐Female ☐Male

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN #: _____ Date of Birth: _____

Employer: _____

How did you hear about us?

☐ 1-800-Dentist ☐ Flyer/Ad ☐ Insurance /Plan Referral: _____

☐ Sign/Building ☐ Marketing Representative: _____

☐ Yellow Pages ☐ Employer ☐ DDS Referral: _____

☐ Family/Friend ☐ Website ☐ Other _____

I hereby certify that the above information is accurate and may be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid for by my insurance company. I hereby authorize payment directly to this professional dental corporation any insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims. I authorize to receive information & alerts from West Coast Dental Services, Inc. via text messages. I understand this program is completely voluntary and that text messaging rates & fees may apply as determined by my cellular provider. West Coast Dental Services, Inc. is in no way responsible for any fees charged to me by my cellular provider. If at any time I wish to discontinue receiving text messages from West Coast Dental Services, Inc. I must notify the office in writing to withdraw from the text program.

_____ _____

Signature of Responsible Party Date

(Parent or Legal Guardian if patient is a minor)

Patient Information Update *Update is noting no major change in Patient Information

Date	Signature	Comments

West Coast Dental Services, Inc.