

# PATIENT INFORMATION

(Please fill in completely)

PATIENT \_\_\_\_\_  
(Last Name) (First) (Middle) (Date)

ADDRESS \_\_\_\_\_  
(Number) (Street) (City) (Zip) (Area)(Telephone)

HOW LONG HAVE YOU LIVED AT THE ABOVE ADDRESS? \_\_\_\_\_

CIRCLE ONE: MISS MRS. MS. MR. DR. CHILD

CIRCLE ONE: SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Drivers Lic # (State) \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How Long Employed \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

IF PATIENT IS MARRIED Spouse's Occupation: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

COMPLETE THIS PORTION Spouse's Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

IF PATIENT IS A MINOR OR Parent or Guardian's Name: \_\_\_\_\_

SOMEONE OTHER THAN THE Person Financially Responsible: \_\_\_\_\_ Soc. Sec # \_\_\_\_\_

PATIENT IS FINANCIALLY Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

RESPONSIBLE, COMPLETE THIS SECTION Address: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Purpose of Today's Appointment: \_\_\_\_\_

Referred By: \_\_\_\_\_

Do you have Dental Insurance Yes No Name of Company: \_\_\_\_\_

Do you have Medical Insurance Yes No Name of Company: \_\_\_\_\_

Kaiser Medical Record # \_\_\_\_\_