Patient Information

Patient Name____ Date:____________
Last First MI

☐
Address ____
Street Apartment #

____
City State Zip Code

SS# ________ - ________ - ____________ DOB__________ DL#____________ State______

Home#____________________Work# ______________________ Ext:_____

Cell#____________________ Email Address______________________________________

☐ Married ☐ Single ☐ Child ☐ Other Male ☐ Female

Emergency Contact(other than spouse) Name____________________ Phone#(____)____________

Address ____ Relationship____________________

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other______________

Name of person or office referring you to our practice:____________________________________

Location Preferred **281/ Babcock/ New Braunfels/ Hwy 87/ Southcross/ No Preference**

Are you available for short notice appointments? Y/N Preferred Doctor______________________

Responsible Party Information

(If same as Patient Info leave blank)

Name: ____________________________ Relationship to patient________________ Male/Female

Address: ____
Street Apartment #

____
City State Zip Code

SS#______________________ DOB___________ DL#_____________ State_____________

Home#________________Work#____________________ Ext.________ Best time to call: _______

Employment Information

Employer Name____________________ Phone#________________ Occupation: __________

Address: ____
Street City State Zip Code

Insurance Information

Primary

Name of Insured______________________________________ Are you the insured? ☐ Yes ☐ No
Last First MI

Insurance Plan Name and Address: ____

Insurance Phone #______________________ Employer Name__________________________

Insured's DOB_______________ ID#____________________ Group#__________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other___________

Secondary

Name of Insured______________________________________ SS#___________________
Last First MI

Insurance Plan Name and Address: ____

Insurance Phone #______________________ Employer Name__________________________

Insured's DOB_______________ ID#____________________ Group#__________________

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other______________