THEODORE A. TANABE, D.D.S.

PATIENT INFORMATION RECORD

Date: ______________________________

Patient Name: ☐ Mr. ☐ Mrs. ☐ Ms. ______________________________
First Middle Initial Last

Address: ______________________________
Street Apt. # City State Zip

Phone: (_____) ______________ Cell: (_____) ______________ Birthdate ___________ Age: _______

Social Security #: ______________________________

Employer: ______________________________ Occupation: ______________________________

Address: ______________________________

City: ______________________________ Zip: ______________ Phone: (_____) ______________

Name of Spouse: ______________________________ Date of Birth: ______________________________

Social Security Number: ______________________________

Employer: ______________________________ Occupation: ______________________________

Address: ______________________________

City: ______________________________ Zip: ______________ Phone: (_____) ______________

Dentist: ______________________________ **Orthodontist:** ______________________________

Referred by: ______________________________

Physician: ______________________________

Nearest Friend or Relative: ______________________________ Phone: ______________

INSURANCE INFORMATION

Primary Dental Insurance: ______________________________ Group #: ______________

Address: ______________________________

Subscriber Name (insured): ______________________________

Secondary Dental Insurance: ______________________________ Group #: ______________

Address: ______________________________

Subscriber Name (insured): ______________________________

Primary Medical Insurance: ______________________________ Group #: ______________

Address: ______________________________

Subscriber Name (insured): ______________________________

Secondary Medical Insurance: ______________________________ Group #: ______________

Address: ______________________________

Subscriber Name (insured): ______________________________