

# Patient Information

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Sex \_\_\_\_\_ Birth Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Texas Drivers License Number \_\_\_\_\_

Address \_\_\_\_\_ Apartment Number \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ How Long? \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Spouse's Name \_\_\_\_\_  
Last First Middle

Spouse's Social Security Number \_\_\_\_\_ Spouse's Birth Date \_\_\_\_\_

Spouse's Work Phone Number \_\_\_\_\_

Previous Address \_\_\_\_\_ Apartment Number \_\_\_\_\_

Previous City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Name and address of nearest relative not living with you  
\_\_\_\_\_  
Last First Middle  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

## **Dental Insurance**

### **PRIMARY CARRIER - Patient's Insurance**

Company \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security Number of Insured \_\_\_\_\_

### **SECONDARY CARRIER - Spouse's Insurance**

Company \_\_\_\_\_ Group Number \_\_\_\_\_

Name of Insured \_\_\_\_\_ Social Security Number of Insured \_\_\_\_\_

## **EMPLOYMENT**

Occupation \_\_\_\_\_ Spouse Occupation \_\_\_\_\_

Company Name \_\_\_\_\_ Company Name \_\_\_\_\_

How Long? \_\_\_\_\_ How Long? \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*