UKIAH FAMILY DENTISTRY PATIENT INFORMATION FORM

Last Name: _____First Name: _____ Middle Name: _____

Name you go by: _____ Sex: Male☐ Female☐

Mailing Address: _____City: _____State:____ Zip: _____

Cell #: _____Home #: _____ Work #: _____ May we call work? Yes☐ No☐

Email: _____ DOB: _____/_____/_____ Marital Status: _____

Employer Name and Phone: _____

How did you hear about us? _____

Emergency contact: _____Phone:_____

All new patient/account information is verified with a driver's license or state issued ID. _____

As a courtesy we provide appointment reminders.

Choose **ONE** option for calls 1 week and 1 day before your appointment: Home☐ **OR** Cell☐ **OR** Work☐

Do you wish to receive a **TEXT** 28 and 4 days before your appointment? Yes☐ No☐

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to Patient: _____

PRIMARY DENTAL INSURANCE COVERAGE:

Policyholder/Subscriber's Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Employer Name:_____

Employer Address:_____

DOB: _____-_____-_____ID#_____OR SSN: _____-_____-_____

Group#:_____Insurance Company Phone: _____

Insurance Company Name:_____

Please give card to staff or supply address: _____

SECONDARY DENTAL INSURANCE COVERAGE:

Policyholder/Subscriber's Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Employer Name:_____

Employer Address:_____

DOB: _____-_____-_____ID#_____OR SSN: _____-_____-_____

Group#:_____Insurance Company Phone: _____

Insurance Company Name:_____

Please give card to staff or supply address: _____

As a courtesy, we are happy to assist you with insurance billing. All account balances are the responsibility of the account holder.

Signature of Patient/Guardian: _____Date: _____