

# Patient Information



Patient Name \_\_\_\_\_ BestTime to Call \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Male  Female

Marital Status:  Single  Widowed  Married / Spouse's Name \_\_\_\_\_

Occupation \_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Employer Address \_\_\_\_\_

### Insurance Information

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's ID or SSN # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

### Secondary Insurance

Subscriber's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Subscriber's ID or SSN # \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

### Contact Information

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Numbers:

Home (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Do you receive text messages on your cell phone?  Yes  No

Email \_\_\_\_\_

### Emergency Contact Person:

Name \_\_\_\_\_

Tel (\_\_\_\_) \_\_\_\_\_ Relationship \_\_\_\_\_

### COSMETIC DENTISTRY

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