**APEX DENTAL**

**PATIENT INFORMATION SHEET**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Patient’s Name: |  |  |  |  |  |  |  |  |  |  |  |  |  | Date of Birth: |  |  |  |  | Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ | Sex: | M | F |
|  |  |  |  |  |  |
|  | SSN: |  |  |  |  | Marital Status: M / S / W / D | No. of Dependents: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |
|  | Address: |  |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |
|  | Home Phone #: |  |  |  |  |  |  |  |  | Cell Phone #: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_ \_ |  |
|  |  |  |  |  |  |  |  |  |
|  | Employer: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone: |  |  |  |  | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |
|  | Spouse: |  |  |  |  |  |  |  |  |  |  | SSN: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Date of Birth: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Employer: |  |  |  |  |  |  |  |  |  | Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_ |  |  |  |  | \_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Emergency Contact Person: |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Address: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Have you been seen in another Apex Dental location? | Yes | No |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | **PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT** |  |  |  |  |  |  |  |  |  |
|  | Name of Responsible Person: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Residence Address: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Home Phone #: |  |  |  |  |  |  |  |  |  |  |  | SSN: \_\_\_ |  |  |  | \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_ Date of Birth: | \_\_\_ \_ \_\_\_\_\_\_\_\_\_ |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Employer: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | # of Years Employed: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Employers Address: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Union Local #.: |  |  |  |  |  |  |  |  | Wk. Phone #: |  |  |  |  |  |  |  |  |  |  |  |  |  | Dental Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  | **IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | **PRIMARY INSURANCE** |  |  |  |  |  |  |  |  |  |  | **(Use your Identification Card)** |  |  |  |  |  |  |  |  |  |
|  | Insured’s Name: |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \_\_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Patient’s Relationship to Insured: Self | / Spouse / | Child |  | / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Employer: | \_\_\_\_\_\_\_\_ |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone #: |  |  |  |  |  |  |  |  | Union Local: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  | Insurance Company: \_\_\_\_\_ |  |  |  |  |  |  |  | ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |



Claims address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **SECONDARY INSURANCE** | **(Use your Identification Card)** |  |  |  |  |  |  |
| Insured’s Name: |  |  |  | \_\_\_\_\_\_\_\_\_ |  | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient’s Relationship to Insured: Self | / Spouse / Child / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Employer: | \_\_\_\_\_\_\_\_ |  |  |  | Phone #: |  | Union Local: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |
| Insurance Company: \_\_\_\_\_ |  | ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Claims address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_