



Patient Information Sheet

Date _____

PATIENT

Last Name: _____ First Name: _____ Int. _____
 Home Phone Number: () _____ Foster child: yes no
 Home Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____
 Social Security #: _____ DL #: _____ Date of Birth: _____ Sex: (M) (F)
 How did you hear about us? _____
 In case of emergency, contact: (Name) _____ (Phone number) () _____

FATHER / GUARDIAN

Last Name: _____ First Name: _____ Int. _____
 Home Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____ Home Phone Number: () _____
 Social Security #: _____ DL #: _____ Date of Birth: _____
 Employer: _____
 Position: _____
 Work Address: _____
 City: _____ State: _____ Zip: _____
 Work Phone Number: () _____ Ext. _____ Relation To Patient: _____
 Insurance Carrier: _____ Subscriber ID: _____
 Policy Number: _____ Plan Number: _____

MOTHER / GUARDIAN

Last Name: _____ First Name: _____ Int. _____
 Home Address: _____ Apt # _____
 City: _____ State: _____ Zip: _____ Home Phone Number: () _____
 Social Security #: _____ DL #: _____ Date of Birth: _____
 Employer: _____
 Position: _____
 Work Address: _____
 City: _____ State: _____ Zip: _____
 Work Phone Number: () _____ Ext. _____ Relation To Patient: _____
 Insurance Carrier: _____ Subscriber ID: _____
 Policy Number: _____ Plan Number: _____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the Dentist and his staff to determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the Dentist and his staff. I also understand that if the Dentist is going to extend credit for my child's treatment, a credit history may be obtained.

Signature of Patient

Date

Signature of Responsible Party

Date

TO BE COMPLETED BY DIAMOND SPRINGS DENTAL CENTER

COVERAGE: _____ DENTI-CAL _____ INSURANCE: _____ CASH: _____ PREPAID: _____

Pre Paid Plan or Insurance Carrier: _____ Plan # or Policy #: _____

Phone #: () _____ Coverage or Liability Verified by: _____

Employment Verified by: _____ Approved by: _____ Date: _____