allen orthodontics

w. michael allen, d.d.s, m.s.

Confidential Patient Information Form

Patient Information

Patient's Name _____ Today's Date _____

Patient's Address _____

Social Security Number _____ Birth Date _____ Home Phone _____ Parent's/Guardian's Name _____

Other Family Members Seen By Us _____

General Dentist's Name _____ Who Referred You to Us? (We would like to thank them) _____

Responsible Party Information

Name _____ ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Other Marital Status _____

Home Address _____

Mailing Address _____ Years at this Address _____

Social Security Number _____ Birth Date _____ Home Phone _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ Years Employed _____

Spouse's Name _____

Social Security Number _____ Birth Date _____ Home Phone _____ Relationship to Patient _____

Employer _____ Work Phone _____ Occupation _____ Years Employed _____

Insurance Information

Policy Holder's Name _____ Social Security Number _____

Insurance Company Name _____ Group Number _____

Insurance Company Phone Number _____

Policy Holder's Employer _____

Do you have Dual Coverage? ☐ Yes (Complete this Section) ☐ No

Policy Holder's Name _____ Social Security Number _____

Insurance Company Name _____ Group Number _____

Insurance Company Phone Number _____

Policy Holder's Employer _____

Emergency Contact Information

Name of Nearest Relative NOT Living With You _____ Relationship _____

Address _____ Phone _____