# Patient Information Form

## WE'D LOVE TO KNOW: HOW DID YOU HEAR ABOUT US?

_____

### PATIENT

Name _____ Social Security# _____
Last First

Address _____ Apt# _____ City _____ Zip _____

Home Phone (_____) _____ Cell (_____) _____

Email _____ Age _____ Birthdate _____

### RESPONSIBLE PARTY (If same as above, skip) **Relationship to Patient** _____

Name _____ Social Security# _____
Last First

Address _____ Apt# _____ City _____ Zip _____

Phone (_____) _____ Age _____ Birthdate _____

### EMPLOYMENT

Work Phone (_____) _____ Ext _____

Occupation _____ Employer _____

Business address _____ City _____ Zip _____

### EMERGENCY CONTACT PERSON

Name _____ Phone (_____) _____
Last First

Physician _____ Phone (_____) _____

### INSURANCE / DENTAL PLAN

(PRIMARY)

Plan Name _____ Member ID: _____

(SECONDARY)

Plan Name _____ Member ID _____

**All unpaid insurance claims are the responsibility of the patient or guardian.**

*I understand and agree that (regardless of my insurance), I am ultimately responsible for the balance of my account for any services rendered. I have read all information on the Privacy Practice and Disclosure Act and have completed the answers on this page (front/back). I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status, health, and/or medication history. I hereby give my consent to Monfredi Family Dental, LLC, to send mailings, send email reminders and messages, place phone calls or text messages to my addresses and/or phone numbers provided regarding upcoming appointments, insurance items, or any communication pertaining to my clinical care. You may also leave messages at my home, work, or cellular phone.*

***First Visit:*** _____
Signature of Responsible Party or Patient Date

***Reviewed:*** _____
Signature of Responsible Party or Patient Date

***Reviewed:*** _____
Signature of Responsible Party or Patient Date

***Reviewed:*** _____
Signature of Responsible Party or Patient Date