PALO ALTO ORAL HEALTH

Please complete the following Confidential Information

PATIENT INFORMATION

Email _____

Date _____ Home Telephone _____ Mobile _____

Name _____ Employer _____

Address _____ Business Address _____

City _____ Zip Code _____ City _____

Birthdate _____ Age _____ Social Security # _____

Marital Status _____

Former Dentist's Name _____ Address _____

IF THE PATIENT IS A CHILD

Name of Parent or Guardian _____

School _____ Grade _____

SPOUSE INFORMATION

Name _____ City _____

Employer _____ Business Phone _____ Ext. _____

Business Address _____ Position _____

Whom may we thank for referring you? _____

GENERAL INFORMATION

Person to contact for emergency _____ Person responsible for account _____

Relationship to patient _____ Relationship to patient _____

Their telephone _____ Billing Address _____

IF YOU HAVE DENTAL INSURANCE, PLEASE FILL IN THE FOLLOWING:

PRIMARY CARRIER

Name of insured _____ Birthdate: _____

Social Security # _____

Insurance carrier name _____

Insurance Address _____

City, ST _____

Group # _____

Employer _____

SECONDARY CARRIER

Name of insured _____ Birthdate: _____

Social Security # _____

Insurance carrier name _____

Insurance Address _____

City, ST _____

Group # _____

Employer _____