

PATIENT INFORMATION

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

**Today’s Date: Whom may we thank for referring you?**

Patient’s Name: Nickname/Prefer to be called:

 Last First Middle

Patient’s Address:

 Street Apt City State Zip

Alternate/Mailing Address:

 Street Apt City State Zip

Contact Numbers: ( ) ( ) ( ) ( )

 Home Cell Work Other

E-mail: \_\_\_\_ Facebook:

Preferred method of communication (check as many as you’d like): 🞎Phone 🞎E-mail 🞎Facebook (private message) 🞎Text to cell phone

Sex: 🞎Male 🞎Female Date of Birth: Age: Social Security #:

 month/day/year

Marital Status: 🞎Single 🞎Married 🞎Separated 🞎Divorced 🞎Widowed Spouse’s Name:

Occupation:

Employer’s Name: Employer’s Phone: ( )

Employer’s Address:

 Street City State Zip

Whom should we contact in case of an emergency?

Name:

Address:

 Street Apt

 City State Zip

Contact Numbers: ( ) ( )

 Home Cell

 ( ) ( )

 Work Other

Relationship:

Name:

Address:

 Street Apt

 City State Zip

Contact Numbers: ( ) ( )

 Home Cell

 ( ) ( )

 Work Other

Relationship:

If the patient is under 18 years of age:

Parent/Legal Guardian:

 Last First Middle

Address:

 Street Apt City State Zip

Alternate/Mailing Address:

 Street Apt City State Zip

Contact Numbers: ( ) ( ) ( ) ( )

 Home Cell Work Other

Sex: 🞎Male 🞎Female Date of Birth: Age: Social Security #:

 month/day/year

Marital Status: 🞎Single 🞎Married 🞎Separated 🞎Divorced 🞎Widowed Spouse’s Name:

Insurance Information:

**By signing this form, I assign all insurance benefits for services rendered, otherwise assignable to me, to Drs. Grosleib and/or Valley Village Dental. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.**

Responsible party signature Date

**I certify that all the above information is true and correct to the best of my knowledge as of the date indicated below. I understand that I am financially responsible for all charges, whether or not paid by my insurance company.**

Responsible party signature Date

Primary Insurance: Secondary Insurance:

Subscriber: Subscriber:

 Last First Middle Last First Middle

Social Security #: Date of Birth: Social Security #: Date of Birth:

mo/dy/yr mo/dy/yr

Policy/Group #: Policy/Group #:

Employer: Employer:

Employer’s Address: Employer’s Address:

Employer’s Phone #:( ) Employer’s Phone #:( )