PERIODONTICS OF SOUTHERN ILLINOIS

WELCOME TO OUR OFFICE

PATIENT INFORMATION – PLEASE PRINT

DATE: _____ BIRTH DATE_____ SOC SEC #_____

PATIENT'S NAME _____ PREFERRED NAME _____

ADDRESS: _____
STREET CITY STATE ZIP

HOME PHONE_____ CELL PHONE_____ ☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED

EMPLOYER_____ OCCUPATION_____ WORK PHONE # _____EXT____

ADDRESS _____
STREET CITY STATE ZIP

ALTERNATE CONTACT PERSON _____ PHONE # _____

HAVE WE HAD THE PLEASURE TO TREAT YOU IN THE PAST? YES / NO IF YES… WHEN? _____ WHO? _____

REFERRING DENTIST? _____

☐PARENT OR ☐ SPOUSE INFORMATION –(PLEASE CHECK ONE)

NAME_____ BIRTH DATE _____HOME PHONE_____

ADDRESS_____
(IF DIFFERENT THAN ABOVE) STREET CITY STATE ZIP

EMPLOYER NAME & ADDRESS _____
NAME STREET CITY STATE ZIP

OCCUPATION_____ WORK PHONE#_____ SOC SEC #_____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURED NAME _____

RELATIONSHIP TO PATIENT ☐SELF ☐ SPOUSE ☐CHILD

EMPLOYER_____

NAME OF INSURANCE_____

ADDRESS _____
STREET CITY STATE ZIP

BIRTH DATE_____ SOC SEC # _____

SECONDARY INSURANCE

INSURED NAME_____

RELATIONSHIP TO PATIENT ☐SELF ☐ SPOUSE ☐CHILD

EMPLOYER_____

NAME OF INSURANCE_____

ADDRESS_____
STREET CITY STATE ZIP

BIRTH DATE_____ SOC SEC # _____