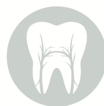

HARPETH
—ENDODONTICS—

Patient Information Form

Date:_____/_____/_____

Patient Legal Name: ____

First *Last* *Middle Initial*

Preferred Name:____________________________ Salutation: Ms. Mrs. Mr. Dr. Other______

Address: ____

Street *City* *State* *Zip*

Phone: ____

Home *Mobile* *Work*

E-Mail Address:____

Social Security Number:________________________*(We have to have this for billing purposes)*

Date of Birth:_____/_____/_____ Sex (Assigned at birth): [ ] Male [ ] Female

Marital Status: [ ] Married [ ] Single [ ] Divorced [ ] Separated [ ] Widow

Occupation:____ Full-Time Student: [ ] Yes [ ] No

If yes, name of school:____

Is patient a minor? [ ] Yes [ ] No If yes his/her primary residence: [ ] Both Parents [ ] Mom [ ] Dad [ ] Step Parent [ ] Shared Custody [ ] Guardian

Preferred Pharmacy Name and Phone: ____

Person Responsible For Payment

Relationship to Patient: [ ] Self [ ] Spouse [ ] Parent [ ] Other_________________________

(If Self Continue to next section)

Legal Name:____ DOB:_____/_____/_____

Address: ____

Street *City* *State* *Zip*

Phone: ____

Home *Mobile* *Work*

E-Mail Address: ____

Dental Benefit Plan Information

Primary Dental Plan:____________________________ Dental plan Phone:_________________

Name of Insured:____________________________________ Date of Birth:_____/_____/_____

Subscriber ID#:_____________________________ Subscriber SSN#:______________________

Group #:_______________________Group Name/Employer:_____________________________

Patient Relationship to Subscriber:____

Secondary Dental Plan:__________________________ Dental plan Phone:_________________

Name of Insured:____________________________________ Date of Birth:_____/_____/_____

Subscriber ID#:_____________________________ Subscriber SSN#:______________________

Group #:_______________________Group Name/Employer:_____________________________

Patient Relationship to Subscriber:____