

APEX DENTAL
PATIENT INFORMATION SHEET

Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____ Sex: M F

SSN: _____ Marital Status: M / S / W / D No. of Dependents: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Employer: _____ Phone: _____ Occupation: _____

Spouse: _____ SSN: _____ Date of Birth: _____

Employer: _____ Occupation: _____ Phone #: _____

Emergency Contact Person: _____ Relationship: _____

Address: _____ Phone: _____

Referred by: _____ Have you been seen in another Apex Dental location? Yes No

PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT

Name of Responsible Person: _____ Relationship: _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ SSN: _____ Date of Birth: _____

Employer: _____ # of Years Employed: _____

Employers Address: _____ City: _____ State: _____ Zip: _____

Union Local #: _____ Wk. Phone #: _____ Dental Insurance: _____

IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW

PRIMARY INSURANCE

(Use your Identification Card)

Insured's Name: _____ SSN: _____

Patient's Relationship to Insured: Self / Spouse / Child / Other _____ Date of Birth: _____

Employer: _____ Phone #: _____ Union Local: _____

Insurance Company: _____ ID #: _____ Group #: _____

Claims address: _____ Phone #: _____

SECONDARY INSURANCE

(Use your Identification Card)

Insured's Name: _____ SSN: _____

Patient's Relationship to Insured: Self / Spouse / Child / Other _____ Date of Birth: _____

Employer: _____ Phone #: _____ Union Local: _____

Insurance Company: _____ ID #: _____ Group #: _____

Claims address: _____ Phone #: _____