

Adult Patient Information Form

Patient Information	last name	first name	middle name	preferred name
	street address		city	state zip
	home phone	work phone	cell phone	email
	social security number	birth date (mm/dd/yyyy)	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	<input type="checkbox"/> M <input type="checkbox"/> F
	marital status	sex		
	occupation	employer		
	work address	city	state	zip
	referred by	present dentist		
	emergency contact	phone		
	physician	phone		
physician address	city	state	zip	
Primary Dental Insurance	insured's name	insured's employer		
	insured's birth date	insured's social security number or identification number	relationship to patient	
	insurance company	phone number	group number	
	insurance company address	city	state	zip
Secondary Dental Insurance	insured's name	insured's employer		
	insured's birth date	insured's social security number or identification number	relationship to patient	
	insurance company	phone number	group number	
	insurance company address	city	state	zip

I authorize Dr. Lefkoff to release any information requested by any third party payer regarding charges incurred by this patient. In addition, I authorize the use of the signature on all insurance submissions.

Signature

Date