Personal Care Dental Group LLC

Patient Information Form

Welcome! For us to better serve you, please fill out these forms completely.

Mission Statement: To improve the quality of life for every individual who visits our office by protecting, promoting, and educating them on their oral health. To provide high-quality dentistry, with an emphasis on prevention, to individuals, in and around our community within a comfortable and friendly environment that is reflective of our commitment to personal care.

About You

Name _____

Preferred Name _____ ☐ Male ☐ Female

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Birthdate ___/____/____ Age _____ SS# _____

Driver's License #: _____

Address _____

City _____ State _____ Zip _____

Home # _____ Cell # _____

Work # _____ Fax # _____

Email _____

How did you hear about our office? _____

Responsible Party

Person responsible if patient is a dependent

Name _____ Relation _____

Billing Address _____

City _____ State _____ Zip _____

Phone # _____ Birthdate ___/____/____

Email _____

Spouse Info

Name _____

Cell # _____ Work # _____

Birthdate ___/____/____

Insurance Info

Insurance Company Name _____

Subscriber Name _____

Member #/SSN _____ Group # _____

Subscriber Employer _____

Insurance Company Phone # _____

Relationship to Subscriber _____

Secondary Insurance Info

Insurance Company Name _____

Subscriber Name _____

Member #/SSN _____ Group # _____

Subscriber Employer _____

Insurance Company Phone # _____

Relationship to Subscriber _____