Patient Information

Please Print

First: ________________________________Middle Initial: ____Last: ____________________________________Sex: **M F**

Street:____City: _________________State: ___________Zip: _________

Daytime Phone: ____Cell Phone: ____________________________

Email Address: ____May we contact you by Email? **Yes No**

Social Security Number: _________________________________Date of Birth: _____________________

Emergency Contact: _______________________________________Phone: ____

How did you hear about Elite Dentistry of Pasadena?

Newspaper Radio TV Internet Referral Other: _________________________________

Insurance Information

Do you have Dental Insurance? (circle) **Yes No** Do you have Secondary Dental Insurance? (circle) **Yes No**

Primary Insured		**Secondary Insured**	
Subscriber Name		Subscriber Name	
Subscriber SSN		Subscriber SSN	
Date of Birth		Date of Birth	
Relationship to Subscriber	Self Spouse Child Other	Relationship to Subscriber	Self Spouse Child Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	
Please present card to receptionist to be photocopied			

Preferred Appointment Times: (day of week and time) ____

Spouse or Responsible Party Information:

First: ________________________________Middle Initial: ____Last: ____________________________________Sex: **M F**

Street:____City: _________________State: ___________Zip: _________

Daytime Phone: ____Cell Phone: ____________________________

Email Address: ____Relationship to Patient**:**______________________________