OREGON MOBILE DENTISTRY

Patient Information

Patient Name: _____ _____ ____ _____
LAST FIRST MI PREFERRED NAME

Date of Birth: _____ **Sex:** Male Female **Phone**: _____ **Email:** _____

Primary Care Physician:_____ **PCP Phone**:_____ PCP Fax:_____

Pharmacy:_____ Pharmacy Phone:_____ Pharmacy Fax:_____

Facility/Care Home Name (if applicable): _____ **Contact:**_____

Facility phone: _____ Fax:_____ Email: _____

Patient OR Facility Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Contact Information

Guardian/Power of Attorney/Other: _____ **Relation to patient:** _____
(NAME)

Phone: _____ Email: _____

Address: _____ _____ _____ _____
STREET CITY STATE ZIP

Dental Insurance Information

Insurance Company: _____ **Group#:** _____

Subscriber Name: _____ **Relationship to Patient:** _____

Subscriber ID#: _____ **Subscriber Birthday:** _____

By signing this form, you will consent to our use and disclosure of your protected health information to carryout treatment, payment activities, and healthcare operations.

Signature: _____ Date: _____
Guardian/Patient/Power of Attorney