OREGON MOBILE DENTISTRY

Patient Information

Patient Name: _____
LAST FIRST MI PREFERRED NAME

Date of Birth: _____ **SS#** _____ **Marital Status:** S M Other

Sex: Male Female **Email Address:** _____

Patient Address: _____
STREET CITY STATE ZIP

Patient Phone: _____ **who referred you to us?** _____

Guardian Contact Information

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

Phones: Home_____ **Cell**_____ **Work** _____

Address: _____
STREET CITY STATE ZIP

Email Address: _____

Emergency Contact: _____
NAME AND PHONE NUMBER IF DIFFERENT THAN ABOVE

Dental Insurance Information

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

_____
INSURANCE BILLING ADDRESS INSURANCE PHONE NUMBER

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

Subscriber SS# or ID#: _____**Subscriber Birthday:** _____

Subscriber's Employer: _____**Employment Status:** _____

Employer Address: _____
STREET CITY STATE ZIP

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.

X_____
MUST SIGN HERE **Guardian/Patient/Power of Attorney** **Date**