

# Confidential Patient Information – II

## PERSONAL INFORMATION *(Please Print Legibly)*

Patient's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Kaiser #: \_\_\_\_\_ Pharmacy: \_\_\_\_\_

Student Status: Full / Part-time School Name: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

Primary Ins.: \_\_\_\_\_ Employee SSN: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Insured Employee: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

Secondary Ins.: \_\_\_\_\_ Employee SSN: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_

Insured Employee: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy #: \_\_\_\_\_

## PATIENT CONTACT INFORMATION

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

## PATIENT INFORMATION

SSN: \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Marital Status: \_\_\_\_\_

## PERSON RESPONSIBLE FOR THE ACCOUNT

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Drivers License: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

**I understand that payment is my obligation regardless of insurance or any other third party involvement.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_