DR KANDARE
THE COMFORT DENTIST

PATIENT INFORMATION FORM

PERSONAL INFORMATION

DATE:_____ PATIENT NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: (HOME) _____ (WORK) _____

(CELL) _____ EMAIL: _____

BIRTH DATE: _____ AGE: _____ SEX: _____ EMPLOYER NAME: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW

EMERGENCY CONTACT: _____ TELEPHONE: _____

DENTAL POLICY HOLDER INFORMATION

POLICY HOLDER NAME: _____ SSN: _____ BIRTH DATE: _____

TELEPHONE: (CELL) _____ INSURANCE NAME: _____

INSURANCE PHONE #: _____ INSURANCE ADDRESS: _____

INSURANCE ID #: _____ GROUP #: _____

GENERAL INFORMATION

PLEASE LET US KNOW WHO WE CAN THANK FOR REFERRING YOU: _____

CHIEF DENTAL COMPLAINT TODAY: _____

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? IF YES, PLEASE EXPLAIN:

_____

_____

DATE OF LAST EXAM: _____ WHAT WAS THE EXAM FOR: _____

HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? YES NO

IF YES, WHAT REASON? _____

ARE YOU CURRENTLY RECEIVING CARE? YES NO NATURE OF CARE: _____

NAME OF PHYSICIAN: _____ TELEPHONE: _____