

Patient Information Sheet

DATE 07/04/25
CHART # 1234

PATIENT INFORMATION

FIRST NAME <u>John</u>		MI <u>A</u>	LAST NAME <u>Doe</u>		DOB <u>12/25/80</u>	SEX <u>M</u>
SSN <u>123-01-4444</u>	ID TYPE (SELECT ONE) <input checked="" type="radio"/> DRIVER'S LICENSE		STATE ID	FEDERAL ID	PASSPORT	OTHER
E-MAIL <u>John@fake.com</u>		HOME PHONE <u>555-1234</u>	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY	
HOME ADDRESS <u>123 Fake Street</u>		APT <u>6</u>	CITY <u>Fakesville</u>		ST <u>MN</u>	ZIP <u>12345</u>
EMPLOYER <u>Fake Inc.</u>		POSITION <u>CEO</u>		HOW LONG? YEAR <u>10</u> MONTH <u>2</u>		
EMPLOYER ADDRESS <u>123 Fake Street</u>		CITY <u>Fakesville</u>		ST <u>MN</u>	ZIP <u>12345</u>	

RESPONSIBLE PARTY (DISREGARD IF SAME AS ABOVE)

FIRST NAME <u>John</u>		MI <u>A</u>	LAST NAME <u>Doe</u>		DOB <u>12/25/80</u>	SEX <u>M</u>	RELATIONSHIP TO PATIENT <input checked="" type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> OTHER <input type="radio"/> PARENT
SSN	ID TYPE (SELECT ONE) <input checked="" type="radio"/> DRIVER'S LICENSE		STATE ID	FEDERAL ID	PASSPORT	OTHER	DRIVER'S LICENSE/ID #
E-MAIL		HOME PHONE	CELL PHONE	WORK PHONE	PREFERRED LANGUAGE DECLINED TO SPECIFY		
HOME ADDRESS		APT	CITY		ST	ZIP	
EMPLOYER		POSITION		HOW LONG? YEAR MONTH			
EMPLOYER ADDRESS		CITY		ST	ZIP		

MEDICAL CONTACTS: CURRENT DENTIST

DENTIST NAME <u>Jane Doe</u>	PHONE NUMBER <u>555-1234</u>
ADDRESS <u>123 Fake Street</u>	CITY <u>Fakesville</u> ST <u>MN</u> ZIP <u>12345</u>

EMERGENCY CONTACTS

CONTACT #1 FIRST NAME <u>Jane</u>	LAST NAME <u>Doe</u>	RELATIONSHIP TO PATIENT <u>Spouse</u>
E-MAIL <u>jane@fake.com</u>	HOME PHONE <u>555-1234</u>	CELL WORK PHONE
CONTACT #2 FIRST NAME	LAST NAME	RELATIONSHIP TO PATIENT
E-MAIL	HOME PHONE	CELL WORK PHONE

PRIMARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME <u>John</u>		LAST NAME <u>Doe</u>	
DOB <u>12/25/80</u>	SEX <u>M</u>	INSURED'S RELATIONSHIP TO PATIENT <input checked="" type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> OTHER <input type="radio"/> PARENT	
HOME ADDRESS <u>123 Fake Street</u>		APT <u>6</u>	
CITY <u>Fakesville</u>	ST <u>MN</u>	ZIP <u>12345</u>	INSURED'S SSN
EMPLOYER		EMPLOYER'S PHONE NUMBER	
INSURANCE COMPANY		INSURANCE COMPANY'S PHONE NUMBER	
GROUP #		POLICY #	
POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER		

SECONDARY INSURANCE

INSURANCE CARD PROVIDED

INSURED'S FIRST NAME		LAST NAME	
DOB	SEX	INSURED'S RELATIONSHIP TO PATIENT SELF SPOUSE OTHER PARENT	
HOME ADDRESS		APT	
CITY	ST	ZIP	INSURED'S SSN
EMPLOYER		EMPLOYER'S PHONE NUMBER	
INSURANCE COMPANY		INSURANCE COMPANY'S PHONE NUMBER	
GROUP #		POLICY #	
POLICY EFFECTIVE DATE	UNION NAME AND LOCAL UNION NUMBER		

INITIALS OF PATIENT
INITIALS OF RESPONSIBLE PARTY