MICHAEL A. SCHNEIDER, D.M.D. AND ASSOCIATES

ABOUT YOU — PATIENT INFORMATION

Today's Date: _____

Name: _____ I Prefer to be called: _____ ☐ Male ☐ Female
Last First Mi Mr Mrs Ms Dr

Birthdate ___/___/___ Age: _____ Social Security #: _____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Home Address: _____
Street City State Zip

Home Phone #: (___) _____ Pager/Cell#: (___) _____ Work Phone #: (___) _____ Ext: _____ Driver Lic.# _____

Where & when are best times to reach you? _____ Whom may we Thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

PERSON TO CONTACT IN CASE OF EMERGENCY

His/Her Name: _____ Relation: _____ Work Phone #: (___) _____ Home Phone #: (___) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone Number#: (___) _____ Social Security#: _____

Employer: _____ Work Phone#: (___) _____ Ext. _____ Drivers License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His/Her Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Work Phone#: (___) _____ Ext. _____ Drivers Lic.# _____

INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone#: (___) _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's Social Security: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance

Insurance Co. Name: _____ Phone#: (___) _____ Group # (Plan, Local or Policy#): _____

Insurance Co. Address: _____

Insured's Name: _____ Insured's Social Security: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

DOCTOR'S NOTES

Medical History Notes Date	Comments	PT Int.
1		
2		
3		

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