Patient Information

Today's date: ____________________

Name (first, MI, last)**:**____

Preferred Name ("nickname")**:** ____

Date of birth:__________________ **Age**: ___________ **SS#** ____________________ **Gender:** ☐ **Male** ☐ **Female**

Address (street, city, state, ZIP)**:**____

Home phone:________________________________ **Work phone:**______________________________

Mobile phone:______________________________**E-mail:**________________________________

Employer:____________________________**Occupation:**___________________**Work phone:**__________________

Work address (street, city, state, ZIP)**:**______________________________________

Names of other CCID patients in your family: ____________________________________

Whom may we thank for referring you? If you were not referred, how did you hear about our office?

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Emergency Contact: __________________________**Phone:** _______________ **Relationship:** ____________________

Employer:___________________________**Occupation:**_____________________**Work phone:**__________________

Work address (street, city, state, ZIP)**:**______________________________________

Dental Benefit Plan Information

Primary **dental insurance company:** ______________________________________

Address on Ins Card (street, city, state, ZIP)**:** ____________________________

Name of insured: ________________________________ **Date of birth:**________________________________

SS/ ID number:_____________________________________**Policy/Group number:**______________________________

Employer:______________________________**Patient relationship to insured:**________________________________

Patient Communications

Is there anyone else you would like to authorize to have access to your protected health information?

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Our office uses mailings, land-line calls, cell-phone calls, voicemail messages, text messages, and e-mail to communicate with our patients regarding anything pertaining to their treatment at Cleveland Center for Integrative Dentistry.

I authorize voice and digital communications via: ☐ **Phone** ☐ **Cell Phone** ☐ **Voicemail** ☐ **E-mail** ☐ **Text**

Patient Signature : ____Date:________________