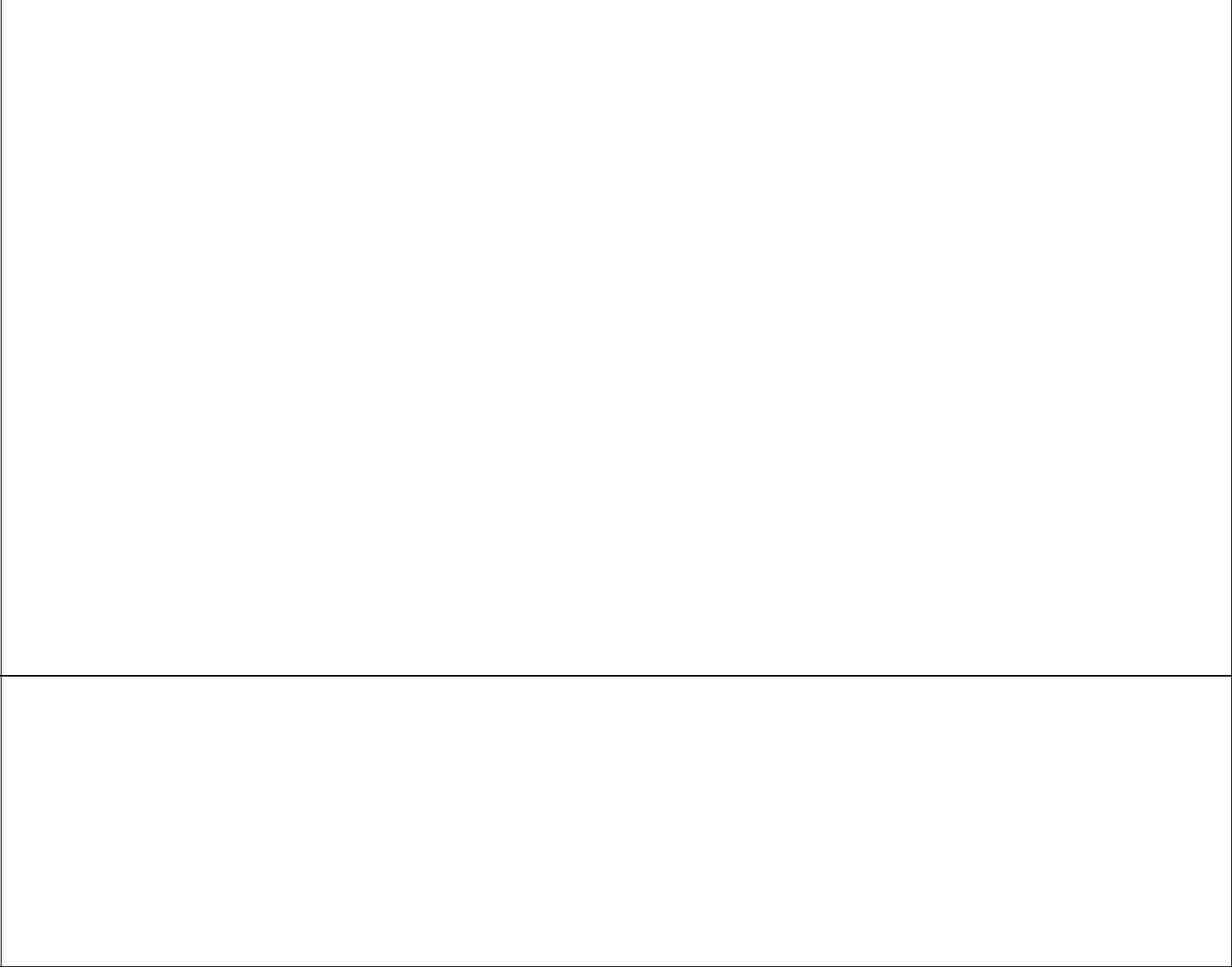
**APEX DENTAL**

**PATIENT INFORMATION SHEET**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  | Patient’s Name: | | | | | | |  | |  |  |  |  |  |  |  |  |  |  |  |  | Date of Birth: | | | | | | | | | | | | | | |  |  |  |  | Age: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | Sex: | M | | F | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | |  |  | | | | | | | | | | | | | | | | | | | | | |
|  | SSN: | | | | | | |  | |  |  |  | Marital Status: M / S / W / D | | | | | | | | | | | | No. of Dependents: \_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Address: | | |  | | | | | |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Home Phone #: | | | | | |  | | |  |  |  |  |  |  |  | Cell Phone #: | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | \_ \_ | |  |
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|  | Employer: | | | | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone: | | | | | | | | | | | | |  |  |  |  | Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | |
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|  | Spouse: | |  |  | | | | | |  |  |  |  |  |  |  |  | SSN: | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Date of Birth: \_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | | |  |  |  | |  |  |  |  |  |  |  | |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  |  |
|  | Employer: | | |  | | | | | |  |  |  |  |  |  |  |  | Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  | \_\_\_\_\_\_\_ | | | |  |
|  |  | |  |  |  |  |  |  |  | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | |  | |  |  |  |  |  |  |  |  |  |  |  |  | |  |  | | | | |  |  |
|  | Emergency Contact Person: | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Address: | |  | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  |  |  |  |  |  |  | | | |  |  |  | | | |  |  | |  |  | | |  |  |  | | |  |  |  |  |  |  | | | |  | |  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  | |  |  |  |
|  | Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | Have you been seen in another Apex Dental location? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | Yes | No | |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | |  |  | |  |  | | |  |  |  | | |  |  |  |  |  |  | | | | | |  |  |  |  | |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  | **PERSON RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |
|  | Name of Responsible Person: | | | | | | | | | | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Residence Address: | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Home Phone #: | | | | | |  | |  |  |  |  |  |  |  |  |  |  | SSN: \_\_\_ | | | | | |  |  |  | \_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_ Date of Birth: | | | | | | | | | | | | | | | | | | | | | | | | | | \_\_\_ \_ \_\_\_\_\_\_\_\_\_ | | | | | | | |  |
|  |  | | |  | |  |  |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | | |  | |  |  | |  | |  | |  |  |  | |  |  | | | | |  |  |
|  | Employer: | | |  | | |  | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | # of Years Employed: \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Employers Address: | | | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  | Union Local #.: | | | | |  | | |  |  |  |  |  |  |  | Wk. Phone #: | | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  | Dental Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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|  |  |  |  |  |  |  | **IF DENTAL INSURANCE WILL BE INVOLVED, PLEASE COMPLETE INFORMATION BELOW** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |
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|  | **PRIMARY INSURANCE** | | | | | | | | |  |  |  |  |  |  |  |  |  |  | **(Use your Identification Card)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  |  |  |  |  |  |  |  |  |
|  | Insured’s Name: | | | | | | |  | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | \_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |  |  |  |  |  |  |  | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | |  | | | | | | | |  | | | | | |  |  | |  |  | |  | | | |  | |  | | | | | | | | | |  |  | | | |  | | | |  | |  | | | | | |  | |
|  | Patient’s Relationship to Insured: Self | | | | | | | | | | | | | | | / Spouse / | | | | | | Child | | |  | / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | |  | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | |  | |  | | |  |  |  |  |  |  |  |  |  | | | | | | | |  | |  | | | | | |  | |
|  | Employer: | | | | | | | | | \_\_\_\_\_\_\_\_ | | | | |  |  |  |  |  |  |  |  |  |  |  |  |  |  | Phone #: | | | | | | | |  |  |  |  |  |  |  |  | Union Local: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | |
|  |  | | |  | | | | | | | | | | | |  |  |  |  |  |  |  |  | | |  | |  | | | | | |  | | | | | | | | | | |  | | | | | | | | | |  | | | | | |  | |
|  | Insurance Company: \_\_\_\_\_ | | | | | | | | | | | | | | |  |  |  |  |  |  |  | ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |  |  | | | | | | |  | | | | |  | | | | |  |  |  | | |  | | | | | | | | | | | | | | | | | |



Claims address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SECONDARY INSURANCE** | | | | | **(Use your Identification Card)** | | | | | | |  |  |  |  |  |  |
| Insured’s Name: | |  |  |  | \_\_\_\_\_\_\_\_\_ | | | | | |  | SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
|  |  |  |  | |  |  |  |  |  |  |  | |  |  |  |  |  |
| Patient’s Relationship to Insured: Self | | | | | / Spouse / Child / Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  |  |  |  | |  |  |  |  |  |  |  |  |  | |  |  |  |
| Employer: | | \_\_\_\_\_\_\_\_ | | |  |  |  | Phone #: | | | |  | Union Local: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  | |  | |  |  |  |  | |  | |  |  | | |  |  |
| Insurance Company: \_\_\_\_\_ | | | | |  | ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |  | Group # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Claims address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_