Henna Sandhu, D.D.S.

Patient Information Record

Please Use Blue or Black Ink Today's Date_____

Patient Information

Patient's Name_____
First Middle Initial Last

Mailing Address_____

City_____ State_____ Zip_____

Street Address (if different)_____

Birthdate_____ Age_____ Sex M / F Driver license #_____

If Student Name of School\College_____ City\State_____

Occupation_____ Employer_____

Has anyone in your family been a patient here before? **Yes \ No** Name(s)_____

Whom May we Thank for Referring You_____

Name of Dentist_____ Phone Number_____

Name of Physician_____ Phone Number_____

Pharmacy_____ Phone Number_____

Phone Numbers

Home (____)_____ Work (____)_____ ext._____ Cell (____)_____

Best Phone number to reach you at between 8am to 4:30pm _____

Emergency Contact_____ (____)_____

Responsible Party Information/Dental Insurance (Primary Insurance)

Do You Have Dental Insurance ☐ Yes ☐ No

Name of Insured or Responsible Person_____ Relation to Patient_____

Birthdate_____ Driver License #_____

Employer_____ Work Phone Number (____)_____

Insurance Company_____ Subscribers Id # _____

Insurance Company Phone Number (____)_____ Group Number_____

Additional Dental Insurance (Secondary Insurance)

Name of Insured_____ Relation to Patient_____

Birthdate_____ Drivers License #_____

Employer_____ Work Phone Number (____)_____

Insurance Company_____ Subscribers Id # _____

Insurance Company Phone Number (____)_____ Group Number_____

Patient / Guardian Signature_____ **Date**_____

Print Name_____ Relationship_____

Acknowledgement of Receipt of "Notice of Privacy Practices"

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I have received a copy of this office's Notice of Privacy Practices.

Signature_____ Date_____

A parent or guardian must sign if patient is under 18.

Email:_____