Patient Information

Please Print

Patient Name _____ Date of Birth _____ Male/Female

If minor, Parent's Name _____ Home Phone _____

Mailing Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Email _____

Driver's License/ID # _____ State Issued _____ Expires _____

Dental Insurance Carrier _____ Phone _____

Subscriber's Name _____Date of Birth _____

Subscriber's Social Security # _____ Group # _____

Patient Primary Physician _____ Phone _____

Is patient being treated for any medical condition: List _____

Current Medications _____

EMERGENCY Contact Name _____ Phone _____

Name of Pharmacy _____ **Location** _____

Phone _____

Primary Reason for your visit today: _____

How did you hear about Texas Allsmiles: _____

Patient/Legal Guardian Signature _____ **Date** _____