

**James J. Flaggert III, D.D.S.**

PATIENT INFORMATION FORM

Today's Date: \_\_\_\_\_

Have you come to see us in the past? Y N

First Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name : \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home telephone # (\_\_\_\_) \_\_\_\_\_ Other telephone # (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Student: FT PT

Whom may we thank for referring you to our office: \_\_\_\_\_

Who will be responsible for account? \_\_\_\_\_ Relation: Self Spouse Mother Father

Name: \_\_\_\_\_ Telephone # \_\_\_\_\_

Street: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance telephone # \_\_\_\_\_

Policy/Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Patient Relation to Policy Holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Telephone # \_\_\_\_\_

Policy/Group #: \_\_\_\_\_ ID#: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Patient Relation to Policy Holder: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder SS#: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder Employer: \_\_\_\_\_