

# Stanislaus Oral Surgery and Implantology

Date \_\_\_\_\_

## PATIENT INFORMATION

Have you ever been seen in our office before?  Yes  No

Patient Name \_\_\_\_\_

Address \_\_\_\_\_  
*No PO boxes please.*

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

SSN# \_\_\_\_\_

Driver's License # \_\_\_\_\_

Are you a full-time student?  Yes  No

If yes, name of school attending? \_\_\_\_\_

## SPOUSE INFORMATION

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## PARENT INFORMATION *(for patient 18 years or younger)*

**Father's Name** \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SSN# \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Occupation \_\_\_\_\_

REFERRED BY \_\_\_\_\_ GENERAL DENTIST \_\_\_\_\_

INSURANCE INFORMATION	Primary Dental	Secondary Dental	Medical Insurance
Insured Employee			
Social Security #			
Date of Birth			
Employer			
Group/Policy/Medical Record # <i>(need Kaiser # for patient)</i>			
Name of Insurance			