EVAN S. HALPERN, DDS
PRACTICE LIMITED TO ENDODONTICS
A Professional Corporation

909.989.0899 PHONE 909.989.1499 FAX 10801 FOOTHILL BLVD. STE 103, RANCHO CUCAMONGA, CA 91730

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION

NAME:_____ ☐MR. ☐MRS. ☐MISS. ☐MS. ☐DR.
(LAST) (FIRST) (MI)

I PREFER TO BE CALLED:_____ ☐MALE ☐FEMALE BIRTH-DATE__/__/__.

SS#_____ KAISER MR# (IF APPLICABLE) _____

HOME ADDRESS: _____
(NUMBER) (STREET) (APT#) (CITY) (STATE) (ZIP)

HOME PHONE (____) _____ CELL/PAGER (_____) _____ WORK (_____)_____

EMPLOYER: _____ OCCUPATION: _____

SPOUSE/PARENT INFORMATION

NAME: _____ SS#_____ BIRTH-DATE__/__/__.
(LAST) (FIRST) (MI)

WHO MAY WE THANK FOR REFERRING YOU? _____ PHONE: (___)_____.

PHYSICIAN: _____ PHONE: (___)_____.

WHEN & WHERE IS THE BEST TIME TO REACH YOU? _____

ANY FAMILY MEMBERS SEEN BY US? _____

IN THE EVENT OF AN EMERGENCY, IS THERE SOMEONE WHO LIVES NEARBY THAT WE SHOULD

CONTACT? _____
(NAME) (RELATION) (HOME#) (WORK#)

PLEASE PROVIDE US WITH YOUR INSURANCE INFORMATION

_____
(NAME & ADDRESS OF INSURANCE COMPANY)

_____
(GROUP MEMBER) (EMPLOYER) (PHONE#)

_____
(INSURED'S NAME) (RELATION) (BIRTHDAY) (SS#) (ID#)

DO YOU HAVE SECONDARY INSURANCE COVERAGE?

_____
(NAME & ADDRESS OF INSURANCE COMPANY)

_____
(GROUP MEMBER) (EMPLOYER) (PHONE#)

_____
(INSURED'S NAME) (RELATION) (BIRTHDAY) (SS#) (ID#)