



RICHARD C. FUGLER, D.D.S., M.D.

## PATIENT INFORMATION

**Welcome to our office. So that we may assist you in filing your health insurance forms, please provide us with the information requested below. All information is kept confidential.**

Patient's Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Soc. Sec. #: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address if different from above: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ How do you prefer to be contacted? Check Below:

Cell Phone (Text)     Cell Phone (Call)     Home Phone     Work Phone     E-Mail

Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Soc. Sec. #: \_\_\_\_\_ Drivers License # \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Responsible Party Phone #: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Referring Dentist: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Pharmacy Location: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Family members who have been patients here: \_\_\_\_\_