CARING HANDS DENTAL CLINIC
PATIENT IDENTIFICATION FORM

Patient Name:_____ Patient Birth Date:_____

Address:_____ Phone:_____

City, State, Zip:_____ Alternate Phone:_____

Email:_____ Today's Date:_____

County of Residence:_____ Group Home:_____

Employer:_____ Employer Phone:_____

Martial Status: Single:☐ Married:☐ Gender: Male:☐ Female:☐

Language Used: English:☐ Spanish:☐ Other:_____

Ethnic Background (optional):

Hispanic:☐ African American:☐ American Indian:☐ Asian:☐ White:☐

If there is a legal guardian, please fill in the information below:

Parent's Name:_____ Phone:_____

Parent's Address:_____ Work Number:_____

_____

Guardian's Name:_____ Phone:_____

Guardian's Address:_____ Work Number:_____

_____

Please fill out this section completely, including telephone numbers:

Physician:_____ Phone:_____

Address:_____

Previous Dentist:_____ Phone:_____

Address:_____

Pharmacy:_____ Phone:_____

Medical Insurance:

(Check one)

PrimeWest:☐ Blue Plus:☐ Medica:☐ VA:☐ MA:☐ Health Partners:☐ UCare:☐

ID #: _____ _____ _____ _____ _____ _____ _____ _____

"I authorize the release of my medical information to my insurance carrier as necessary to process any claims. I authorize payment of medical benefits to Caring Hands Dental Clinic for services rendered."

I also authorize release of my dental and medical information to:_____

Patient/Guardian Name (please print)_____

Patient/Guardian Signature:_____ Date:_____