UT★Dentists
A Part of UTHealth

For Office Use:
EHR #: _____

Patient Profile

Are you a NEW patient? [ ]Yes [ ]No

Date/ Time of Appt: _____

PATIENT INFORMATION

Sex/ Gender: [ ]Male [ ]Female

Patient Name: _____

Date of Birth: _____ **SS #:** _____

Address: _____

Marital Status: [ ]Married [ ]Single [ ]Divorced [ ]Widow

_____

Preferred Language: [ ]English [ ]Spanish [ ]Vietnamese [ ]Other: _____

City: _____ **State & Zip:** _____

Race: [ ]American Indian/ Alaskan Native [ ]Asian/ Indian [ ]Black/ African American [ ]Hispanic/ Spanish [ ]Middle Eastern [ ]Native Hawaiian/ Other Pacific Islander [ ]Some other race/ origin [ ]White [ ]Unknown [ ]Decline to Answer

Phone: _____ [ ]Hm [ ]Cell [ ]Wk

Phone: _____ [ ]Hm [ ]Cell [ ]Wk

Phone: _____ [ ]Hm [ ]Cell [ ]Wk

Ethnicity: [ ]Hispanic or Latino [ ]Non-Hispanic or Latino [ ]Unknown [ ]Decline to Answer

Email: _____

Referred by: [ ]Insurance Plan [ ]UT Dentist Website [ ]Family [ ]Friend [ ]UTHealth Employee [ ]Other:_____

Primary Care Doctor:_____ **Primary Care Phone Number:** _____

Referring Doctor:_____ **Referring Doctor Number:** _____

EMERGENCY CONTACT

Name: _____ Relationship: _____ Best Contact Number:_____

PATIENT EMPLOYMENT

[ ]Employed [ ]Retired [ ]Unemployed [ ]Other Occupation: _____

Employer: _____ **Phone:** _____

GUARANTOR INFORMATION

[ ]Same as Patient [ ]Parent/ Guardian, if under 18 years old

Guarantor Name: _____ **Guarantor Phone:** _____

Address, if different from patient: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____ **Insured ID:** _____ **Group ID:** _____

Relationship to Subscriber: [ ]Self [ ]Child [ ]Spouse **Subscriber Name:** _____

Subscriber Birth Date: ____/____/____ **Subscriber Employer:** _____

Secondary Dental/ Medical Insurance (if Applicable): _____ **Insured ID:** _____ **Group ID:** _____

Relationship to Subscriber: [ ]Self [ ]Child [ ]Spouse **Subscriber Name:** _____

Subscriber Birth Date: ____/____/____ **Subscriber Employer:** _____

By signing this form, I attest that the above personal and insurance information provided is true to the best of my knowledge.

_____ _____

Patient / Guarantor Signature **Date Completed**