NewYork-Presbyterian
Queens

DENTAL AND ORAL MEDICINE
PATIENT DEMOGRAPHIC FORM

Is this your first visit? (Circle one) YES NO Date:_____

PLEASE FILL OUT COMPLETELY.
IF IT DOES NOT PERTAIN TO YOU, PLEASE WRITE N/A.

Patient Information

Patient's Name (Last, First, Middle Initial)		Date of Birth	Social Security Number
Gender (Circle one) Male Female	Address (Street, Apt#, City, State, Zip)		
Home Phone #	Work Phone#	Cell Phone#	
Marital Status (Circle one) Single Married	Birth Place	Preferred Language	Race / Ethnic Group
Spouse's Name	Mother's Name	Father's Name	

Emergency Contact Information

Name	Relationship	Home Phone #	Work Phone#	Cell Phone#
Address (Street, Apt#, City, State, Zip)				

Employment Information

(Circle one)
Employed Fac. Employed Independent Retired Student Unemployed

Insurance (Dental)

Name (Last, First, Middle Initial)		Date of Birth	Social Security Number
Address (Street, Apt#, City, State, Zip)			Home Phone #
Name and Address of Employer		Work Phone#	Cell Phone#
Company (Name and Address)	ID#		Group or Plan # (Please list all characters)
Insurer's Name (Whose policy # is on the card)		Patient's Relationship to Insured (Circle one) Self Spouse Child Other_____	

Please present Insurance Card to front desk, so they can make a copy of the front and back of the card.

Insurance (Medical)

Name (Last, First, Middle Initial)		Date of Birth	Social Security Number
Address (Street, Apt#, City, State, Zip)			Home Phone #
Name and Address of Employer		Work Phone#	Cell Phone#
Company (Name and Address)	ID#		Group or Plan # (Please list all characters)
Insurer's Name (Whose policy # is on the card)		Patient's Relationship to Insured (Circle one) Self Spouse Child Other_____	

Please give your Insurance Card(s) to the front desk after filling out this form.