

WELCOME

TODAY'S DATE _____

E-MAIL _____

PATIENT'S LAST NAME _____ FIRST NAME _____ MIDDLE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____ AGE _____

SOCIAL SECURITY # _____ DATE OF BIRTH ____/____/____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ STATE _____ ZIP _____

____ MALE ____ SINGLE ____ DIVORCED
____ FEMALE ____ MARRIED ____ WIDOWED

IS OK TO DISCUSS YOUR DENTAL TREATMENT OR SCHEDULED APPOINTMENTS WITH A FAMILY MEMBER? YES OR NO

IF YES, WHO? _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

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

SPECIAL INTERESTS, SPORTS, HOBBIES: _____

WHO DO WE CONTACT IN CASE OF EMERGENCY?

NAME _____ PHONE # _____ RELATIONSHIP _____

PERSON RESPONSIBLE FOR ACCOUNT:

NAME _____ ADDRESS _____ PHONE# _____

DENTAL INSURANCE CO. _____ INSURANCE PHONE # _____

CARRIER OF INS. _____ BIRTHDATE ____/____/____ SOCIAL SECURITY # _____ EMPLOYER _____