PATIENT INFORMATION
CONFIDENTIAL

BEN GERKIN DDS

DATE ____________________

(PLEASE PRINT)

NAME ____ BIRTHDATE ____________________
FIRST MI LAST

ADDRESS ______________________________ CITY ______________ STATE ______ ZIP ________

HOME PHONE ____________________ CELL PHONE ____________________ WORK PHONE ____________________

SS# ______________________________ EMAIL ______________________________

HOW DO YOU PREFER TO BE CONTACTED FOR ANY APPOINTMENT CONFIRMATIONS/NOTIFICATIONS?

☐ EMAIL ☐ HOME ☐ CELL ☐ WORK ☐ BY MAIL ______________________________

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

WHOM MAY WE THANK FOR REFERRING YOU? ______________________________

PERSON TO CONTACT IN CASE OF AN EMERGENCY ____________________ PHONE ____________________

RESPONSIBLE PARTY

(IF DIFFERENT FROM ABOVE)

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT ____________________ RELATIONSHIP TO PATIENT ____________

ADDRESS ______________________________ HOME PHONE ____________________

E-MAIL ______________________________ CELL PHONE ____________________

BIRTHDATE ______________________________

EMPLOYER ______________________________ WORK PHONE ____________________

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

(IF DIFFERENT FROM ABOVE)

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________________ SS #/ID # ____________________

NAME OF EMPLOYER ____________________ WORK PHONE ____________________

INSURANCE COMPANY ____________________ GROUP # ____________________

INS. CO. ADDRESS ____________________ INS. PHONE # ____________________

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED ______________________________ RELATIONSHIP TO PATIENT ____________

BIRTHDATE ____________________ SS #/ID # ____________________

NAME OF EMPLOYER ____________________ WORK PHONE ____________________

INSURANCE COMPANY ____________________ GROUP # ____________________

INS. CO. ADDRESS ____________________ INS. PHONE # ____________________

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