PATIENT INFORMATION

Title & Name

Date Preferred

Name:

DOB

Marital Status

Sex

Address

City, State, Zip

Home PH:

Work Phone

Cell

Email

Best way to reach you: Email Text Cell Other

SNN:

Emergency Contact

PH:

Preferred Pharmacy & Location (City)

Employer

Occupation

Whom May We Thank For Referring You To Our Office?

Members of Family Being Treated in our Office:

INSURANCE: Please complete so we may assist you in receiving your insurance benefits

Insurance Policy Holder Primary

Policy Holder DOB:

ID/SSN

Employer

Insurance Company

Group #

Claims Mailing Address

Eligibility #

Insurance Policy Holder Secondary

Policy Holder DOB

ID/SSN

Employer

Insurance Company

Group #

Claims Mailing Address

Eligibility #

Dental History

Chief Concerns for Today's Visit:

Do You Wish To Speak With The Doctor Privately About Any cares or Concerns? Yes No

I will allow Susan A. Sheets, DOS to discuss my condition(s} with my physician and/or other treating providers via email or other means and to request information from them as necessary.

(initial)

I will allow Susan A. Sheets, DDS to photograph and use for educational and marketing purposes, via email or other means, any aspects of my defltal condition(s) or treatment procedures.

(initial)

Signature

Date