lechtenberg & young DENTAL

Patient Name________________________ Preferred Name______________ Today's Date________

Birth Date______________ Social Security Number______________ Sex: ◯Male ◯Female

Home Address________________________ City/State/Zip________________________

Home Phone______________ Cell Phone______________ E-mail________________________

Contact Preference: ◯Home Phone ◯Cell Phone ◯Text ◯Email ◯Work Phone Marital Status: ◯Single ◯Married ◯Divorced

Parent(s) Name(if minor) or Spouse Name______________ ______________ Phone______________

Patient or Parent's Employer________________________ May we contact you at work? ◯Yes ◯No

Employer Phone______________ Address______________________ City/State/Zip______________

Person to Contact in case of Emergency______________________ Phone______________ Relation______________

What is the primary reason for your visit today? ________________________________

Do you love your smile? ◯Yes ◯No Is there anything you would like to change? ______________________

Previous DDS______________________ Reason for Leaving________________________

Who may we thank for referring you? ________________________________

Do you have a Doctor preference in our office? ________________________________

<u>Insurance:</u>

Primary Insurance:

Name of Insured________________________ Employer________________________

Birth Date__________ SSN/Member ID______________ Insurance Company______________

Secondary Insurance:

Name of Insured________________________ Employer________________________

Birth Date__________ SSN/Member ID______________ Insurance Company______________