

DR. G. KIRK GLEASON

DR. ALFRED HOLLIS

DR. LISA BERLS

PATIENT NAME \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ SEX \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

IF CHILD, BOTH PARENT'S NAMES \_\_\_\_\_

PERSON RESPONSIBLE FOR BILL, IF NOT LISTED:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ ZIP \_\_\_\_\_  
FOR EMERGENCY PURPOSES, NAME AND ADDRESS OF NEAREST RELATIVE NOT LIVING AT YOUR HOME

PATIENT ADDRESS \_\_\_\_\_  
(street) (city) (zip)

HOME PHONE # (\_\_\_\_) \_\_\_\_\_ BUSINESS PHONE # (\_\_\_\_) \_\_\_\_\_ CELL # (\_\_\_\_) \_\_\_\_\_

E-MAIL ADDRESS \_\_\_\_\_ S.S. # \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PRESENT POSITION \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

**PRIMARY DENTAL INSURANCE:** INSURANCE COMPANY \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ S.S. # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE NUMBER (\_\_\_\_) \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

**SECONDARY DENTAL INSURANCE:** INSURANCE COMPANY \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ S.S. # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_ BUSINESS ADDRESS \_\_\_\_\_

BUSINESS PHONE NUMBER (\_\_\_\_) \_\_\_\_\_ GROUP NUMBER \_\_\_\_\_

HOW LONG SINCE YOUR LAST DENTAL EXAMINATION? \_\_\_\_\_

PREVIOUS DENTIST'S NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

WHAT DO YOU PLAN TO HAVE DONE TODAY? \_\_\_\_\_  
IF YOU COULD CHANGE ANYTHING WITH YOUR SMILE, OR YOUR MOUTH, WHAT WOULD YOU DO? \_\_\_\_\_

IF CHILD, ARE THEY TAKING ANY FLUORIDE SUPPLEMENTS? \_\_\_\_\_

IF CHILD, PARENT OR GUARDIAN'S SIGNATURE \_\_\_\_\_

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**WE WELCOME YOU TO OUR OFFICE. PLEASE FEEL FREE TO ASK US ANYTHING!**