

DR. G. KIRK GLEASON

DR. LISA T. 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!

