GIFFORD FAMILY DENTISTRY
Gentle • Friendly • Trusted

About You

Today's Date:_____

E-mail Address:_____
*We promise to never sell your email address and will not share it with those not directly associated with our practice.

Name:_____
Last First Mi
Mr Mrs Ms Dr

Name I prefer to be called: _____

Birthdate: _____/_____/_____ **Age:**_____

SS#_____ ☐Male ☐Female

Home Address:_____

_____

Mailing Address:_____

_____

Home Phone:_____ **Cell:**_____

Work: _____ **Ext.** _____

Driver's License #:_____

Whom may we thank for referring you?

_____

Other family members seen by us:_____

_____

Employer:_____

How long there?_____**Occupation:**_____

☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Minor**

Spouse Information / Parent Information (if patient is a minor)

Name:_____
Last First Mi
Mr Mrs Ms Dr

Birthdate: _____/_____/_____ **Age:**_____

SS#_____ ☐ **Male** ☐ **Female**

Home Phone:_____ **Cell:**_____

Work: _____ **Ext.** _____

Driver's License #:_____

Employer:_____

How long there?_____**Occupation:**_____

Emergency Contact Information

Name:_____

Relationship:_____

Home Phone:_____ **Cell:**_____

Work: _____ **Ext.** _____

Insurance Information

Primary Dental Insurance:_____
Address:_____
Phone:_____
Subscriber:_____
Subscriber ID#:_____
Subscriber Date of Birth:_____
Subscriber relation to the patient:_____

Secondary Dental Insurance:_____
Address:_____
Phone:_____
Subscriber:_____
Subscriber ID#:_____
Subscriber Date of Birth:_____
Subscriber relation to the patient:_____

I hereby authorize any associate of Gifford Family Dentistry to release any and all dental information to process my insurance claim. I hereby authorize my insurance company to pay directly to Gifford Family Dentistry all dental benefits due me, by reason of dental services rendered. I understand I am financially responsible to the dentist for charges not covered by this authorization.

SIGNATURE OF PATIENT (or guardian) _____**Date:**_____