Welcome

Thank you for choosing and trusting our practice for your dental needs. We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us. We will be happy to help.

Patient Information

Patient name:_____ Date of birth: ___/___/_____ Age:_____ Sex: M or F

Home address:_____ City:_____ State:___ Zip:_____

Billing address (if different):_____ City:_____ State:___ Zip:_____

Home #: (_____) _____-_____ Work #: (_____) _____-_____ Cell #: (_____) _____-_____

SS#: _____-___-_____ Occupation:_____ Name of Employer:_____

Spouse's name:_____ Spouse's Daytime Telephone: (_____) _____-_____

Name of previous dentist:_____ Date of last visit to dentist:_____

Referred to us by:_____

Insurance Information

Subscriber name:_____ Date of birth: ___/___/_____ SS#: _____-___-_____

Subscriber's home address:_____ City:_____ State: ___
Zip:_____

Subscriber's employer:_____ Primary insurance:_____ Group #:_____

Do you have secondary insurance coverage: Yes or No (if no, proceed to the dental health history section)

Subscriber name:_____ Date of birth: ___/___/_____ SS#: _____-___-_____

Subscriber's home address:_____ City:_____ State: ___
Zip:_____

Subscriber's employer:_____ Secondary insurance:_____ Group #:_____

Emergency Contact

In case of an emergency, who should we contact (other than spouse):_____

Relation to you:_____ Contact's home #: (_____) _____-_____ Contact's work #: (___) _____-_____

Name of medical doctor:_____ Medical doctor's telephone: (_____) _____-_____

Date of last visit to medical doctor:_____

In case of emergency, I give my authorization for Dr. Wyman's office to refer me to the nearest hospital for treatment.

Signature_____ Date:___/_____/_____