Christian R. Willard D.D.S., P.C.

"Helping to Create and Preserve Beautiful Smiles"

Patient's Information

Marital Status S M D W

Name_____

How do you wish to be addressed?_____

Address _____

City, State, Zip_____

Home Phone_____

Work Phone_____

Cell Phone_____

E-Mail Address_____

Date of Birth_____

Social Security Number_____

Employer_____

Employer Address_____

_____

Employer Phone Number_____

May we contact you (and leave messages) at the above numbers to confirm appointments Y N

**IF NOT, please specift appropriate phone numbers

_____

Spouse/Guardian_____

Spouse/Guardian Address_____

City, State, Zip_____

Spouse/Guardian Work Phone_____

Spouse/Guardian Cell Phone_____

Spouse/Guardian Birthdate_____

Spouse/Guardian S.S.N._____

Spouse/Guardian Occupation_____

Spouse/Guardian Employer_____

Person to notify in case of emergency_____

Relationship to patient_____

Phone Number_____

Person(s) you authorize discussion of personal treatment_____

Preferred Pharmacy_____

Physician's Name_____

Physician's Phone Number_____

Who Referred You_____

Dental Insurance

Subscribers Name_____

Subscribers Date of Birth_____

Subscriber S.S.N._____

Relationship to Patient_____

Name of Insurance Co_____

Insurance Co Phone Number_____

Subscriber ID Number_____

Group Number_____

Authorization

I have completed this form fully and completely, and certify that I am the patient or duly authorized general agent of the patient to furnish the information requested.

I understand that even though I might have a form of insurance coverage, I am fully responsible for all the payments at the time of service, including my deductible and co-pay which the insurance does not cover.

I understand that where appropriate, credit bureau reports may be obtained. We accept MasterCard, Visa, American Express, Discover, cash and personal checks.

Signature of Patient, Parent or Responsible Party **Date**

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