

Draper Family Dentistry

*We are committed to providing the highest quality dental care for you
in a manner that empowers you to have ongoing health throughout your life.*

PATIENT INFORMATION

Date _____

1) Name _____ Preferred Name _____
Address _____ Birthdate _____
city state zip Age _____ Male Female
Hm Phone () _____ Soc. Sec. # _____
Wk Phone () _____ Ext. _____ **E-Mail** _____
Cell Phone () _____ (for appointment confirmation only)
FAX () _____ Single Married Divorced Widowed

Full Time Student? YES NO School Name? _____

Whom may we thank for referring you to our office? _____

Have you seen us on: Yelp Y/N Google Y/N Facebook Y/N Draper Family Dentistry website Y/N

RESPONSIBLE PARTY / INSURANCE INFORMATION

2) Name _____ Relationship to patient _____
Residence _____ Birthdate _____
if different from patient's city state zip Soc. Sec. # _____
Hm Phone () _____
Employer _____ Wk Phone () _____ Ext. _____
Address street city state zip

Primary Insurance _____ Group # _____
Insurance Co. Address _____ Phone # _____

3) Spouse _____ Relationship to patient _____
Wk Phone () _____ Ext. _____ Birthdate _____
Employer _____ Soc. Sec. # _____
Address street city state zip

Secondary Insurance _____ Group # _____
Insurance Co. Address _____ Phone # _____

EMERGENCY CONTACT

Whom may we notify in case of emergency?

4) Name _____
Hm Phone () _____
Wk Phone () _____ Ext. _____

Please Complete Both Sides