GRAND BLANC • CLARKSTON

PERIODONTAL SPECIALISTS

World-class care and caring

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Name: _____ Date: _____

Preferred Name: _____ Birth Date: _____ SS# _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please circle your preferences for contacting you when confirming appointments: Home Work Cell Email

E-Mail Address (office use only): _____

Employer: _____ Marital Status: _____

Who do we contact in case of an emergency? _____ Phone: _____

Who may we thank for referring you? _____

Has another family member been a patient here? _____ If yes, who? _____

I understand and agree that I am responsible for full payment of my account, including any amounts above and beyond my dental benefit (insurance) coverage:

_____ _____
Signature *Date*

<u>If you have current dental insurance, please continue form:</u>

Name of Insured Employee: _____ Relationship to Insured: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured SS# _____ Insured Birth Date: _____ Employer: _____

Dental Insurance Co. _____ Group # _____

Medical Insurance Co. _____ Group # _____

<u>Do you have dental insurance coverage from another dental insurance company? If so, please continue form:</u>

Name of Insured Employee: _____ Relationship to Insured: _____

Address: _____ City: _____ State: _____ Zip: _____

Insured SS# _____ Insured Birth Date: _____ Employer: _____

Dental Insurance Co. _____ Group # _____

Medical Insurance Co. _____ Group # _____