Precision Cosmetic Family Dentistry

Please supply the following information in order that we may better serve you.

Name (First, Middle Initial, Last)	Preferred Name ( )	Date / /	Sex ☐ M ☐ F

Address	City	State	Zip	Date of Birth / /	Age

Home Phone ( )	Work Phone ( )	Cell Phone ( )	Social Security Number - -

Email Address

Occupation	Employer

Work Address	City	State	Zip

☐ *This patient is a child and I, ______________________, am the parent or legal guardian and by signing am authorizing treatment.*

Whom shall we contact in the event of an emergency?
Name: Phone ( )

Who is responsible for the payment of this account?

________Self ________Spouse ________Parent ________Other

Patient Status: _____Single _____Married _____Divorced _____Separated _____Widowed _____Child

Spouse or Parent Name: Date of Birth:

Social Security Number: Employer:

Do you have dental insurance? _____Yes _____No

If yes, please present card at front desk, and complete the following…

Insurance Company______________________ Insurance Phone______________________

Insurance Phone______________________ SSN______________________

Contract #______________ Group #__________ Subscriber #______________________