WELCOME! **FIRLIK FAMILY DENTISTRY** Date: _____

PATIENT INFORMATION

Full Legal Name | **Date of Birth** | ***M F*** **Sex**

Social Security Number | **SINGLE MARRIED DIVORCED SEPARATED WIDOWED (Please circle)**

Address

E-mail Address | **Home Telephone** **Cell** **Work Telephone**

Emergency Contact Name & Relationship | **Emergency Contact Telephone Number**

Name of person responsible for your dental account | **If different from above information please provide telephone number**

PRIMARY INSURANCE INFORMATION

Subscriber Name

Birth Date of Insured | **SS# or ID of Insured** | **Home Telephone** | **Cell Phone**

Address if different from patient | **Employer of Insured**

Insurance Company | **Group#/ID#**

SECONDARY INSURANCE INFORMATION

Subscriber Name | **Relationship to Patient**

Birth Date of Insured | **SS# or ID of Insured** | **Home Telephone** | **Cell Phone**

Address if different from patient | **Employer of Insured**

Insurance Company | **Group#/ID#**

MEDICAL HISTORY

PRIMARY CARE PHYSICIAN'S NAME, ADDRESS & TELEPHONE

Date of last physical exam:

Have you been hospitalized for any serious illness or surgical operation? If YES, please explain: