WELCOME

Michael H DeLuca, DDS, Joseph D Schmid, DDS, Megan E Stowers, DDS

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

PATIENT INFORMATION

(Please Print)

Today's Date:_____

Name:_____ I prefer to be called:_____

Home Address:_____ City:_____ State:____ Zip Code:_____

Hm #: (____)_____ Cell #: (____)_____ Wk #: (____)_____ Ext:____

How would you prefer to be contacted: □ Home # □ Work # □ Cell # □ Email

Birthdate:_____ Age:_____ Gender: □ Male □ Female Social Security #:_____-____-_____

Email Address:_____

□ Single □ Married □ Divorced □ Widowed □ Separated □ Minor

Patient Employer/School:_____ Occupation:_____

Employer/School Address:_____ City:_____ State:____ Zip Code:_____

Spouse/Parent's Name:_____ Employer:_____

Wk #: (____)_____ Spouse/Parent's SS#:_____-___-_____ Spouse/Parent's DOB:_____

Whom may we thank for referring you to us?_____

Emergency Contact Person_____ Relationship to patient: _____

Hm #: (____)_____ Cell #: (____)_____ Wk #: (____)_____ Ext:____

RESPONSIBLE PARTY

Person Responsible for account:_____ Relationship to patient: _____

Billing Address:_____ City:_____ State:____ Zip Code:_____

Hm #: (____)_____ Cell #: (____)_____ Wk #: (____)_____ Ext:____

Employer:_____ Social Security #:_____-____-_____

INSURANCE INFORMATION

Primary Coverage

Insured's Name:_____ Relationship to patient:_____

Insured's DOB:_____ Insured's SS#:_____-___-_____ Insured's Employer:_____

Insurance Co.:_____ Group #:_____ Subscriber #:_____

Insurance Co. Address:_____ City:_____ State:____ Zip Code:_____

Insurance Co. Phone #: (____) _____

Secondary Coverage

Insured's Name:_____ Relationship to patient:_____

Insured's DOB:_____ Insured's SS#:_____-___-_____ Insured's Employer:_____

Insurance Co.:_____ Group #:_____ Subscriber #:_____

Insurance Co. Address:_____ City:_____ State:____ Zip Code:_____

Insurance Co. Phone #: (____) _____

MEDICAL HISTORY

Do you have a personal physician? □ Yes □ No Physician's Name:_____

Phone #: (____)_____ Date of Last Visit:_____ Reason for visit: _____

Current physical health is: □ Good □ Fair □ Poor

Are you currently under the care of a physician? □ Yes □ No

If yes, please explain:_____

(CONTINUED ON THE BACK)