THE DENTAL LAB

Dr. Karen Erani, DMD

PATIENT INFORMATION

Date _____/_____/_____.

First Name _____(MI) _____ Last Name _____

I like to be called _____ ☐ Female ☐ Male

Driver's License _____

Date of Birth _____/_____/_____ Age _____Social Security Number _____

Home Phone (_____) _____ Work Phone (_____)_____ Ext _____

Cell Phone (_____) _____ Fax (_____) _____ E-mail _____

Street Address _____City _____ State _____ Zip _____

What number would you like us to call you on regarding your appointments? _____

Name of Employer _____Occupation _____

Who may we thank for referring you to our practice? _____

Previous dentists name _____Phone (_____) _____

Last seen by previous dentist _____/_____/_____Treatment rendered _____

Would you like us to contact your previous dentist for applicable records? ☐ No ☐ Yes

Account Information

Responsible Party's: Self/Other Name _____

Street Address _____ City _____ State _____Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Ext _____

Social Security # _____ DOB _____/_____/_____Driver's License _____

Insurance Information - Primary

Insurance Company's Name _____

Street Address _____ City _____ State _____Zip _____

Insured's First Name _____(MI) _____ Last Name _____

Social Security # _____ DOB _____/_____/_____Driver's License _____

Who should we contact in the unlikely event of an emergency?

Name _____Relationship to patient _____

Home Phone (_____) _____ Cell Phone (optional) (_____) _____