WELCOME TO REESE FAMILY DENTISTRY

Patient's Name ____
Last First Middle Initial

Date of Birth ________________________________ ____M ____F

Parent's name if child _______________________________________

How do you wish to be addressed? _____________________________

Address ____

City, State, Zip ____

Home Phone _________________ Work Phone __________________

Cell Phone ___________________ Email _______________________

Patient/Parent Social Security # _______________________________

Drivers License # ____

Patient/parent Employer _____________________________________

Present Position ______________________ How long held _________

Spouse Name ____

Spouse Social Security #: ____________________________________

Spouse Employer ____

Who is responsible for this account? ____________________________

How did you hear about us? ___________________________________

PRIMARY DENTAL PLAN

Insurance _____________

Subscriber_____________

Contract #_____________

Date of Birth___________

Employer_____________

SECONDARY DENTAL PLAN

Insurance_____________

Subscriber_____________

Contract #_____________

Date of Birth___________

Employer_____________

Are you interested in changing the appearance of your smile? Y or N

Do you have a dental benefit plan that assists you with payment? Y or N

Someone to notify in case of emergency not living with you ____________________________________
Name & Telephone #