DOUGLAS B. GIBBONS, DDS, PC

PATIENT INFORMATION

Name _____ Date ____/____/____ SSN _____
(First) (Mid Init) (Last)

Address _____ City _____ State _____ Zip _____

Birth Date ____/____/____ Home Phone _____ Cell Phone _____ Work Phone _____

Are you: [ ] Minor [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Name of Employer _____ Employer Phone _____

Parent's or Spouse's Name (circle one) _____ Cell Phone _____ Work Phone _____

Person to contact in case of emergency _____ Cell Phone _____ Work Phone _____

If you are a student, name of school/college _____ City _____ State _____

Who referred you to our office? _____

RESPONSIBLE PARTY INFORMATION (Person Insured)

Person financially responsible for this patient's account:

Name _____ SSN _____ Birth Date ____/____/____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION

Insurance Company _____ Group/Member # _____ Effective Date ____/____/____

Address _____ City _____ State _____ Zip _____

Insurance Phone _____ Have you used your insurance/paid deductible for the current year? ____Yes ____No

Name of Employer _____ Work Phone _____

Please read and initial the following statement:
As a courtesy for our patients, we will file a claim and accept assignment of benefits for your dental services with your PRIMARY dental insurer. Patients will be responsible for payment of any outstanding amounts not covered by the PRIMARY insurer. If you have SECONDARY dental insurance, we will send your claim to the company. Any reimbursement from your SECONDARY plan will be sent to YOU. _____

DENTAL HISTORY

Are you having any dental discomfort at this time? ____Yes ____No If Yes, explain _____

Reason for today's visit _____ Date of last exam ____/____/____ Date of last x-ray ____/____/____

How often do you brush? _____ How often do you floss? _____

Name of last Dentist seen _____