Welcome to Gadol Family Dentistry!

Patient Information:

Last Name: _____ First Name: _____ MI: ____ Sex: ☐ M ☐ F

Preferred Name: _____ Birth Date: _____ SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Address: _____

City: _____ State: _____ Zip Code: _____

If patient is a minor.... Name of Responsible Party: _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Other: _____

Contact Information:

Home # (____) _____-_____ Work # (____) _____-_____x_____ Cell # (____) _____-_____

Best way to reach you during the day: ☐ Home ☐ Work ☐ Cell ☐ Email ☐ Other

Preferred email(s): _____

May we contact you by E-mail for correspondence and appointment confirmation? ☐ Yes ☐ No

Other:

Emergency Contact: _____ Phone / Email: _____

Primary Physician: _____ Phone: _____

Whom may we thank for referring you? _____

Dental Insurance: ☐ I do not have dental insurance.

Subscriber Information:

Name: _____ Employer: _____

SSN: _____ DOB: _____ Relationship to Patient: _____

Insurance Information: [Please fill out all information below or provide your insurance card]

Company Name: _____ Phone #: _____

Claims Address: _____ Group #: _____

I hereby authorize the provider to release any information required to process insurance claims and authorize assignment of my insurance rights and benefits directly to the provider for services rendered: _____ (Initials)

I certify that the above information is complete and correct to the best of my knowledge.

SIGNATURE _____ DATE _____

Acknowledgment of Receipt of Notice of Privacy Practices

I have read and/or received a copy of the Notice of Privacy Practices for Gadol Family Dentistry.

SIGNATURE _____ DATE _____