GATEWAY DENTAL CARE

Name : _____

Marital Status : S M W D Birthdate _____

E-mail : _____

Employer : _____ Occupation : _____

If student, name of school : _____

Cell Phone # : (_____)_____ Work Phone # : (_____)_____

Home Phone # : (_____)_____ Best # to Call: _____

Home Address : _____

City : _____ State : _____ Zip : _____

***In case of an emergency*.**

Name : _____

Phone : (_____)_____ Relationship : _____

Primary Insurance :

Policy Holder Name : _____

Insurance Company Name : _____

Secondary Insurance :

Policy Holder Name : _____

Insurance Company Name : _____

How did you hear about us? _____

I hereby authorize the dentist or designated staff to perform diagnostic procedures and treatment mutually agreed upon by me as may be required for proper dental care. I attest to the accuracy of the information on this form.

Patient Signature _____ Date _____