Fisher & Orfaly
DENTAL

PERSONAL INFORMATION

Patient's Full Name: _____

Date of Birth: _____ SSN: _____

Address: _____ Apt. _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

Employer: _____ Work Phone: _____

Legal Guardian Name (if patient is under age of 18) _____

Whom may we thank for your referral? _____

How did you hear about our office? Google _____ Facebook _____ Yelp _____ Other _____

In case of emergency, who should we contact? _____ Phone:_____

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Company: _____

Policy Holder (Subscriber's Name): _____ Relation: _____

Subscriber's ID#: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____

DENTAL HISTORY

When was your last dental cleaning and checkup? _____

Do your grind your teeth? Yes _____ No _____

How do you feel about your smile? _____

_____

_____ _____

Patient Signature or Legal Guardian (if patient is under age of 18) Date