WHEELOCK & ASSOCIATES DENTISTRY
DR. RYAN BALLER & DR. JORDAN WINELAND

PATIENT INFORMATION:

Patient Name: (Last) _____ (First) _____ (Middle) _____ ☐ **Male** ☐ **Female**

Date of Birth:_____ **Social Security #**:_____ **Height**:_____ **Weight**:_____

Address: (Street) _____ (City) _____ (State) _____ (Zip)_____

Cell Phone: _____ **Home Phone**: _____ **Work Phone**: _____

Place of Employment:_____ **Occupation**:_____

Marital Status: (Circle one) *Single* *Married* *Divorced* *Widowed* Spouse's Name:_____

Closest Relative:_____ **Relative Phone**:_____

Last Physical Exam:_____ **Name of Physician**:_____

Please complete the medication list below or attach a copy of your medication list:

CURRENT MEDICATION			
MEDICATION	**TREATMENT FOR**	**MEDICATION**	**TREATMENT FOR**
1		6	
2		7	
3		8	
4		9	
5		10	

Pharmacy of choice:_____ Location:_____

APPOINTMENT NOTIFICATION:

Would you prefer confirmation and appointment reminders by: (Circle Choices) ***Mail & Phone*** &/or ***E-Mail*** &/or ***Text***
E-Mail address if requesting E-Mail notification: _____

DENTAL INSURANCE INFORMATION:

Relationship to the patient: (Circle one) *Self* *Spouse* *Child* *Other*

Name of insured Party: (Last) _____ (First) _____ (Middle)_____

Insured's Social Security Number: _____ **Insured's Date of Birth**: _____

Insured's Address: _____ (City) _____ (State) _____ (Zip)_____

Insured's Phone Number: (Cell) _____(Home) _____ (Work) _____

Insured's Employer: (Name) _____ (Address) _____

Insurance Member ID: _____ **Group Number**: _____

Signature of Parent/Person Completing Form:_____Date:_____

OVER ➔ ➔ ➔ ➔