BLAZER FAMILY DENTISTRY

Welcome!

The mission of our practice is to deliver the highest quality of care in a comfortable, safe, and caring environment. Our priority is to empower patients, through dental education and state-of-the-art technology, to feel confident in making decisions regarding their dental health. It is our goal to celebrate lifelong relationships with our patients and to help them achieve and maintain oral health.

Date _____ ☐ New Patient ☐ Update

PATIENT INFORMATION

TITLE _____ FIRST NAME _____ MIDDLE _____ LAST _____

☐ Male ☐ Female ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

PREFERRED NAME _____ DATE OF BIRTH _____ SOCIAL SECURITY NO. _____

If Child, complete:

PARENT/GUARDIAN NAME(S) _____

If Student, complete: ☐ Full-time OR ☐ Part-time

SCHOOL/LOCATION _____

In the event of an emergency, is there someone who lives near you that we should contact?

NAME _____ RELATIONSHIP _____ TELEPHONE NO. _____

Are other members of your family currently seen by our practice? (Please list below.)

NAME(S) _____

CONTACT INFORMATION

Address _____

What is your preferred form of contact? ☐ Text ☐ Email ☐ Home Phone ☐ Cell Phone

Home Phone _____ Work Phone _____

Cell Phone 1 _____ Cell Phone 2 _____

Email _____

INSURANCE/BENEFIT INFORMATION

Subscriber Information:

_____ _____ Date of Birth: _____ SSN: _____
FIRST NAME LAST NAME

Subscriber Employer: _____ Patient Relationship to Subscriber: _____

Primary Insurance Carrier _____

Group/Policy No. _____

Address: _____

_____

Telephone: _____

Toll Free: _____

Secondary Insurance Carrier _____

Group/Policy No. _____

Address: _____

_____

Telephone: _____

Toll Free: _____

REFERRAL INFORMATION

Were you referred to our practice? By whom?

_____ _____
NAME RELATIONSHIP