McClane DENTISTRY

PATIENT INFORMATION

DATE_____

PATIENT NAME _____SS# _____
LAST FIRST M.I.

ADDRESS_____

CITY_____STATE_____ZIP_____PHONE#_____

PARENT NAME (IF PATIENT IS MINOR)_____

PERSON RESPONSIBLE FOR ACCOUNT_____

DATE OF BIRTH_____SEX_____MARTIAL STATUS_____ OCCUPATION _____

PATIENT'S EMPLOYER _____WORK# _____

EMAIL ADDRESS _____

SPOUSE'S NAME _____ PHONE# _____SPOUSE'S DOB_____

EMPLOYED BY_____SS#_____

IN CASE OF EMERGENCY _____
NAME PHONE#

DENTAL INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE? YES _____NO_____

INSURED'S NAME _____POLICY ID# _____GRP#_____

INSURANCE CARRIER _____INSURANCE PH#_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE _____

TO THE BEST OF MY KNOWLEDGE ALL THE PRECEDING ANSWERS ARE TRUE AND CORRECT. I WILL INFORM YOUR OFFICE OF ANY CHANGES AT THE NEXT APPOINTMENT.

_____
SIGNATURE OF PATIENT OR GUARDIAN DATE

We offer Esthetic, Restorative, Implant Restorative, Sedation, Invisalign and Teeth in a Day
1001 SE Ocean Boulevard ~ Suite 107 ~ Stuart, Florida 34996
(772) 287-0788 ~ Fax (772) 287-0916