Justin Family Dentistry

Family, Cosmetic & Implant Dentistry

Patient Information

We are looking forward to having you join our great family of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to allow you to obtain the healthy teeth and attractive smile you want and deserve. Please complete this form so that we can provide the best care possible for you.

NAME: _____ DATE: _____
Last First Middle

I LIKE TO BE CALLED: _____ EMAIL ADDRESS: _____
□ Male □ Female □ Single □ Married □ Divorced □ Widowed

ADDRESS: _____
Street Apt# City State Zip

BIRTH DATE: _____ TELEPHONE: _____
MM/DD/YY Home Cell

DRIVERS LICENSE# _____ SOCIAL SECURITY# _____

PLACE OF EMPLOYMENT: _____ WORK # _____

Has any member of your family ever been treated in our office? □ Yes □ No If yes, who?_____

Whom may we thank for referring you to our office? (check all that apply)

□ Newspaper □ I saw your sign □ Yellow Pages □ Magazine □ Direct Mail □ Internet
□ Acquaintance: _____ □ Another Dr.:_____

Insured Information	Responsible/Billing Party Information
Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other	Relation to Patient: □ Self □ Spouse □ Parent/Guardian □ Other
Last First MI	Last First MI
Street Address City ST Zip	Street Address City ST Zip
Home/Cell Telephone # Birth Date (MM/DD/YY)	Home Telephone # Cell Telephone #
Employer Dental Insurance Company	Email Address Birth Date (MM/DD/YY)
Insured Social Security # or Insured ID# (if different than social)	Drivers License # Social Security #
Insurance Mailing Address	Employer Work Telephone #
Ins Phone Number Group/Plan Number	

PERSON TO CONTACT INCASE OF EMERGENCY
Outside of immediate family / household

Name: _____Telephone Number: _____

May we leave messages announcing our office name in regards to appointments, treatment, and/or insurance/financials on your voicemail? □YES □NO □YES, with exceptions:_____