



C. Michael Bennett, D.D.S., F.A.G.D., P.C.
David A. Bennett, D.D.S.

PATIENT INFORMATION

Welcome to our office! Thank you for choosing us for your dental care. In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Thank you for your cooperation.

I. PATIENT:

| | | | | | | | |
|---|--|----------------|-----------|---|------------|---------------------|------------|
| PATIENTS FULL NAME | | PREFERRED NAME | BIRTHDATE | | SEX M F | SOCIAL SECURITY NO. | |
| LOCAL RESIDENCE: ADDRESS | | | CITY | STATE | ZIP | RES. PHONE | BUS. PHONE |
| E-MAIL | | | FAX | | CELL | | |
| EMPLOYER | | | | MARITAL STATUS | | | |
| WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE | | | | HAVE ANY IMMEDIATE FAMILY MEMBERS BEEN SEEN IN THIS OFFICE? | | | |

In case of emergency:

Name of nearest adult relative not living with you _____
 Relationship _____ Address _____ Phone _____

II. Person Responsible for Account:

Spouse:

| | |
|-------------------------------------|-------------------------------------|
| NAME _____ | NAME _____ |
| ADDRESS _____ | ADDRESS _____ |
| CITY _____ STATE _____ ZIP _____ | CITY _____ STATE _____ ZIP _____ |
| SS # _____ BIRTHDATE _____ | SS # _____ BIRTHDATE _____ |
| HOME PHONE _____ WORK PHONE _____ | HOME PHONE _____ WORK PHONE _____ |
| EMPLOYER _____ | EMPLOYER _____ |
| DENTAL INSURANCE CO. _____ | DENTAL INSURANCE CO. _____ |
| INSURANCE ADDRESS _____ | INSURANCE ADDRESS _____ |
| GROUP NO. _____ | GROUP NO. _____ |
| INSURANCE PHONE NO. _____ | INSURANCE PHONE NO. _____ |
| PRIMARY OR SECONDARY CARRIER? _____ | PRIMARY OR SECONDARY CARRIER? _____ |

Additional Information _____