MaillouxDentistry
WHERE SMILES BEGIN

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. _____
(CIRCLE ONE) LAST FIRST INITIAL SHORT NAME

Date of Birth: ___ / ___ / ___ Sex: M F

Patient SS #: _____ Driver's License #: _____

Home Address: _____
STREET CITY STATE ZIP

Email Address: _____

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

Patient's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our office? _____

I would like appointment reminders by: Text ☐ Phone call ☐

DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ___ / ___ / ___

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____

DO YOU HAVE OTHER DENTAL COVERAGE?

No Yes, please complete the following:

Subscriber's Name: _____ SS#: _____

Relationship to Patient: _____ Subscriber's Date of Birth: ___ / ___ / ___

Insurance Company Name: _____ Group Number: _____

Employer Name and Full Address: _____ Member ID: _____

Work Phone: _____