Martin & Rutledge
COSMETIC AND FAMILY DENTISTRY

NAME:_____ DOB: _____/_____/_____

ADDRESS:_____ SSN: _____-_____-_____

PHONE:_____EMAIL:_____

EMPLOYER / SCHOOL:_____

CIRCLE ONE: ◯ MINOR ◯ SINGLE ◯ MARRIED ◯ SEPARATED ◯ DIVORCED ◯ WIDOWED

RESPONSIBLE PARTY (FOR MINORS)

NAME:_____ DOB: _____/_____/_____

ADDRESS:_____ SSN: _____-_____-_____

PHONE:_____EMAIL:_____

EMPLOYER:_____

DENTAL INSURANCE

PRIMARY INS: _____ ID / SSN: _____

POLICY HOLDER:_____ DOB: _____/_____/_____

GROUP NUMBER:_____RELATIONSHIP TO PATIENT: _____

SECONDARY INS: _____ ID / SSN: _____

POLICY HOLDER:_____DOB:_____ /_____ /_____

GROUP NUMBER:_____RELATIONSHIP TO PATIENT: _____

IF WE ARE UNABLE TO CONTACT YOU, WHO MAY WE CONTACT?

NAME:_____RELATIONSHIP:_____PHONE: _____

ARE ANY OF YOUR FAMILY MEMBERS PATIENTS IN OUR OFFICE? _____

WHO MAY WE THANK FOR REFERRING YOU? _____

NAME AND LOCATION OF PREVIOUS DENTIST: _____

DO YOU NEED TO PREMEDICATE PRIOR TO HAVING DENTAL TREATMENT? IF YES, PLEASE TELL US ABOUT YOUR CONDITION. _____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? IF YES, PLEASE EXPLAIN:

_____

_____

RESPONSIBLE PARTY SIGNATURE:_____DATE: _____

DOCTOR / HYGIENIST REVIEW: _____ DATE: _____

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