SILVERMAN DENTAL

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us -we will be happy to help.
Whom may we thank for referring you? _____

ABOUT YOU

Name: _____ I prefer to be called_____ [ ] Male [ ] Female
[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____
Home Address: _____
City_____ State____ Zip_____
Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____
Cell: (____) _____
Email_____ _____
Employer: _____

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above Name: _____ Birth date:___/___/___
Relation: _____
Billing Address: _____
City_____ State ____Zip_____
Home Phone: (____) _____ Work: (____) _____ S.S. #: _____
Employer: _____ How long there? _____
Occupation:_____

SPOUSE INFORMATION

[ ] Same as above Name: _____ Birth date: ___/___/___
Employer: _____ Work Phone: (____) _____ ext. _____

DENTAL INSURANCE INFORMATION

Primary Insurance
Insurance Co. Name: _____ Phone: (____) _____
Group/Policy #: _____
Insured Name: _____
Insured Birth date: ___/___/___ Relation: _____
Insured Social Security #: _____
Insured Employer: _____

Secondary Insurance
Insurance Co. Name: _____ Phone: (____) _____
Group/Policy #: _____
Insured Name: _____
Insured Birth date: ___/___/___ Relation: _____
Insured Social Security #: _____
Insured Employer: _____