Office Use Only
_____ Driver's License
_____ Insurance Card
_____ Staff Initials

Family Dental Care of Milford Prof. Assn.

William A. Green, D.M.D. K. Drew Wilson, D.M.D. Joshua T. Osofsky, DMD

PATIENT INFORMATION

Today's Date _____

Circle One: Mr. Mrs. Miss Ms. Dr. What name would you like us to call you? _____

Circle One: Single Married Widowed Divorced **Preferred Doctor: Dr. Green Dr. Wilson Dr. Osofsky**

Patient Name _____ Date of Birth _____
Last First MI

Address _____ Patient Employer _____

City/Town _____ Home Telephone _____

State _____ Zip _____ Work Telephone _____

Social Security Number _____ Driver's License Number _____State _____

Has Dr. Green or Dr. Wilson treated you previously? Yes ____ No ____ E-mail _____

Whom may we thank for referring you to our office? _____

PERSON RESPONSIBLE FOR PAYMENT TO BE MADE AT TIME OF SERVICE

Name _____ Circle One: Self Spouse Parent Other

Social Security Number _____ Driver's License Number _____

Address _____ Employer _____

City/Town _____ Address _____

State _____ Zip _____ State _____ Zip _____

Home Telephone _____ Work Telephone _____

Do you have dental insurance? Yes ___No ____ If "Yes" please complete the following: **(If you have a secondary insurance please use an additional form; indicate patient name and complete the insurance information).**

INSURANCE INFORMATION

Name of Insured _____ Relationship to patient: Circle One: Self Spouse Parent Other

Address _____ City/Town _____ Zip _____

Social Security Number _____ Date of Birth _____ Badge # _____

Insured's Employer _____ Address _____

Home Telephone _____ Work Telephone _____

Insurance Company _____ Group number _____ Phone # _____

Address to send claim _____ State _____ Zip _____

PLEASE COMPLETE BOTH SIDES

Previous Dentist:

Dentist name ____ Phone (______)_________________

Address ____

City/Town ___________________________________ State _________ Zip ____________________

Approximate date of last dental visit ____________________ Reason ___________________________________

Date of last complete series of X-rays ____________________ Date of last dental cleaning ______________________

Medical Doctor:

Physician's name ______________________________________ Phone (______) ______________________

Date of last medical visit _____________________ Reason ____

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In the event of an emergency, who should be contacted?

Name _____________________________________ Relation ____________________________

Address ____

Telephone #1 _________________________________ Telephone #2 _________________________

Additional contact people (not living in the same household)

Name _____________________________________ Telephone ___________________________

Name _____________________________________ Telephone ___________________________

Name _____________________________________ Telephone ___________________________

* *

Are you a student? No ________ Yes _________ If yes: Full time _____ Part time ____

Name of School ______________________________ City/Town ___________________________

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Do you have any specific concerns about dentistry?

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How would you like us to help you today?

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