

Gentle Family Dentistry
2431 Easton Avenue
Bethlehem, PA 18017

610-861-0190

Adult Patient Information

Patient Name _____ M__ F__ Date of birth _____ Age _____

Home # _____ Cell # _____ Email: _____

Home Address _____ City _____ St _____ Zip _____

Your Employer _____ Work # _____

Your Social Sec. # _____ Your Occupation _____

How did you find us?

Yellow pages__ WEB site__ Patient name _____ Insurance website __ Other _____

Spouse Name _____ Spouse Date of Birth _____

Spouse Soc. Sec # _____

Spouse Employer _____ Work # _____

Who do we contact in case of emergency? _____ Phone # _____

Physician _____ Date of last visit _____

Former Dentist _____ Date of last visit _____

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Dental Insurance Information:

Primary Insurance Co. _____ **Group #** _____

Name of Insured _____ Insured's Soc. Sec./ID # _____

Insured Relationship to Patient _____ Date of Birth _____

Secondary Insurance Co. _____ **Group #** _____

Name of Insured _____ Insured's Soc. Sec. #/ID # _____

Insured Relationship to Patient _____

Medical Insurance Co _____ **Grp#** _____

Name of Insured _____ Insured's Soc. Sec.# / ID# _____

Permission is hereby granted to the Doctor to perform any necessary dental work. I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I understand that filling a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the information above.

Signature

Date