Christopher Kindem, D.D.S.
Karen Bennett, D.D.S.
Cosmetic, Implant and General Dentistry

PATIENT INFORMATION

(Please Print)

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we much about the individual as we do about the teeth. No two people are alike. No two mouths are alike. All information, of course, will be held in strict confidence.

PATIENT INFORMATION

Name _____ Cell Phone_____

Address _____

City _____ State_____ Zip _____

Home Phone _____ Work Phone_____ Sex ☐ M ☐ F

Married _____ Single_____ Divorced _____ Separated _____ Widow(ed) _____ Child _____

Social Security # _____ - _____ - _____ Birth date _____ Age_____ E-mail address _____

Patient's employer _____ Occupation _____

Employer's Address _____

Spouse's name (Parent name if minor) _____

Spouse's Employer _____ Occupation _____

Spouse's work phone_____ Cell Phone _____

RESPONSIBLE PARTY FOR PAYMENT (Write "Same" if it is the above patient)

Name _____ Cell Phone_____

Address _____ State _____ Zip _____ Sex ☐ M ☐ F

Social Security # _____ - _____ - _____ Birth date _____ Work Phone _____

Employer _____ Employer Address _____

INSURANCE INFORMATION

Patient's dental insurance _____ Group Number _____

Patient's providing insurance _____

Subscriber's Name _____ Birth date _____ SSN _____ - _____ - _____

Patient's providing insurance _____

RELATIVE WHOM WE CAN CONTACT IN EVENT OF EMERGENCY
(Not in the same household) Name _____ Phone _____

WHOM MAY WE THANK REFERRING FROM YOU? _____

Please let us know if you have any fear of dental treatment so we can better help you _____

Other comments? _____

I VERIFY THE ABOVE INFORMATION AND GIVE MY CONSENT FOR TREATMENT

PATIENT'S (GUARDIAN'S) SIGNATURE _____ **DATE** _____