Patient Information

Date:

Please answer the following questions as accurately as possible. This information is necessary in providing the best service to you and, of course, is confidential. If you have any questions, don't hesitate to ask. Thank you.

***Mathew B. Dorsch,** DDS*

Patient name: DOB: Age: Sex:

If patient is a child, parent or guardian's name: Home phone:

SSN: Employer/Occupation: Work phone:

Email address: Please contact me by: Email ❏ Phone ❏ Both ❏

Emergency name / phone no. *(contact other than spouse)*:

Driver's license #: State: Spouse: Phone:

Home address: City: State: Zip:

Billing address (if different): City: State: Zip:

Present physician: Date of your last visit to medical doctor: Phone:

Previous dentist: City: State: Phone:

Date of last dental treatment: Date of last x-rays:

How did you hear about our office?:

Primary Dental Insurance, if Applicable

Insurance co. name: Address: City: Zip:

Subscriber's name: Address: City: Zip:

Subscriber's SSN: DOB: Employer:

Office phone number: Group number: Anniversary date:

Secondary Dental Insurance, if Applicable

Insurance co. name: Address: City: Zip:

Subscriber's name: Address: City: Zip:

Subscriber's SSN: DOB: Employer:

Office phone number: Group number: Anniversary date:

3400 Squalicum Pkwy., Ste. 107, Bellingham, WA 98225) 360 734 9926) CarrDorschDental.com