fremont dental

W e l c o m e !

FREMONT DENTAL **ph 206.675.0366** **fax 206.675.0466**	To help us meet your entire dental care needs, please fill out this form completely. If you have any questions, please ask us and we will be happy to help.	**3601 FREMONT AVE N** **SUITE 316** **SEATTLE, WA 98103** **www.fremontdental.com**

PATIENT NAME First _____

M.I. ____ Last _____

PHONE H (_____)_____

W (_____)_____x_____

Cell (_____)_____

Best ph# to reach you at during the day? _____

E-MAIL _____

ADDRESS _____

Apt _____City_____

State_____ Zip _____

Billing Address (if different) _____

_____

Apt_____ City_____

State _____ Zip_____

Date of Birth_____ **Sex** ☐ M ☐ F

Social Security #_____

Employer_____

Occupation_____

Marital Status_____

Name of Spouse_____

Name of Medical Doctor_____

Name of Clinic/Hospital_____

Phone (_____)_____

Date of last complete physical_____

Former Dentist_____

City_____State_____

Date of last comprehensive dental exam_____

Date of last series of x-rays_____

Whom may we thank for referring you?

_____

EMERGENCY CONTACT (other than spouse):

Name_____

Relation to patient_____

Phone ☐ H ☐ W ☐ Cell

(_____)_____

PRIMARY DENTAL INSURANCE

Subscriber_____

Social Security #_____

Relation to Patient_____Date of Birth_____

Employer_____

Human Resources/Benefit Coordinator:

Name_____

Telephone (_____)_____x_____

Dental Insurance Co_____

Customer Service Telephone (_____)_____

SECONDARY DENTAL INSURANCE

Subscriber_____

Social Security #_____

Relation to Patient_____Date of Birth_____

Employer_____

Human Resources/Benefit Coordinator:

Name_____

Telephone (_____)_____x_____

Dental Insurance Co_____

Customer Service Telephone (_____)_____

SIGNATURE:	DATE:
SIGNATURE:	DATE:
SIGNATURE:	DATE: