CHELSEA COMPREHENSIVE DENTAL
Ryan A. Draiss, DMD

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Patient Information

Date _____ Age _____

Patient's Name _____
Last First Middle Preferred Name

Address _____
Street City State Zip

Primary Phone _____ Date of Birth_____ Primary Physician _____

If patient is a minor, parent/guardian's full name and relationship _____

Who should we thank for recommending our services? _____

Names , gender and ages of spouse and/or children

Have any been seen in this office?

_____ Yes_____ No_____

_____ Yes_____ No_____

_____ Yes_____ No_____

_____ Yes_____ No_____

Responsible Party Information

Name _____
Last First Middle Marital Status

Residence_____
Street City State Zip

Mailing Address _____
Street City State Zip

Home Phone_____Mobile Phone _____ Work Phone_____

Social Security #_____ Date of Birth_____ Relationship to patient_____

Employer _____ Occupation_____ Number of years employed _____

Email address for appointment reminders _____

Spouse's Name _____
Last First Middle

Social Security #_____Date of Birth_____Mobile Phone_____ Work Phone _____

Employer _____ Occupation_____ Number of years employed _____

Dental Insurance Information

Insured's Name _____
Last First Middle

Insured's Social Security_____ Insured's Date of Birth _____

Insurance Company _____ Phone _____

Claims Address:_____

Group #_____ Contract #_____ Plan/Network Name (PPO, etc) _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient_____ Phone Number_____Alternate Phone Number_____

To the best of my knowledge, the 2 pages of information (front and back) are complete and correct. I give my permission for any photographs, X-Rays or study models to be used for displays at scientific presentations and/or publications of scientific nature or for group purposes to further the science of dentistry. I, the undersigned, agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of your account. I understand credit bureau reports may be obtained where appropriate.

Signature _____ Printed Name _____ Date_____
Patient, Parent or Guardian