J. Robert Foote, Jr., DMD ~ Commonwealth Dental, PSC.

Name: _____ _____ _____
FIRST NAME M.I. LAST NAME

I prefer to be called _____ □ M □ F

Birth date _____ SS # _____

□ Single □ Married □ Divorced □ Widowed □ Separated

Mailing Address: _____

City _____ State____ Zip _____

Physical Address (if different): _____

_____

Home #:(____)_____ Work #:(____)_____

Mobile #:(____)_____ Other #:(____)_____

Employer: _____ How Long? _____

May we call you at work? □ Yes □ No

Best time to reach you and at which phone number?

□ AM □ Afternoon □ PM **AND** □ Home □ Work □ Mobile □ Other

Email Address: _____

Who may we THANK for referring you? _____ _____
FIRST NAM

Do you have any family members that come to Dr. Foote

If so, who? _____

Name of Person Financially Responsible: _____ _____
FIRST NAME LAST NAME

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

If child, lives with: □ Both Parents □ Mom □ Dad □ Other

PARENT/GUARDIAN INFORMATION:

Name: _____ □ M □ F

Home Address: _____

_____

Home #: _____ Work #: _____

Employer: _____

Birth date _____ SS # _____

SPOUSE OR ADD'L PARENT/GUARDIAN INFORMATION:

Name: _____ □ M □ F

Home Address: _____

_____

Home #: _____ Work #: _____

Employer: _____

Birth date _____ SS # _____

DENTAL INSURANCE

Primary Dental Insurance

Ins. Co. : _____

Ins. Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Ins. Phone 1: (____) _____

Policy Holder: _____ _____
FIRST NAME LAST NAME

Group #: _____

Policy Holder's Address if different from left: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Phone #: (____) _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

Birth date _____ SS # _____

Insured's Employer: _____

Secondary Dental Insurance

Ins. Co. : _____

Ins. Address: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Ins. Phone 1: (____) _____

Policy Holder: _____ _____
FIRST NAME LAST NAME

Group #: _____

Policy Holder's Address if different from left: _____
STREET ADDRESS

_____ _____ _____
CITY STATE ZIP CODE

Phone #: (____) _____

Relationship to Patient: □ Self □ Spouse □ Parent □ Other: _____

Birth date _____ SS # _____

Insured's Employer: _____

EMERGENY CONTACT INFO:

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____

Wk #:(____)_____ Hm #:(____)_____

Person Filling Out Form: _____

Signed: _____

Date: _____ Relation: _____