WELCOME TO OUR OFFICE

ROBERT M. KUSHMIDER, D.D.S.
GENTLE DENTAL CARE
1040 SHOEMAKER AVE.
SHOEMAKERSVILLE, PA 19555
(610) 562-2273

TODAY'S DATE _____

Thank you for choosing our office.
In order to serve you properly we will need the following information. (Please print.) All information will be strictly confidential.

Patient's name		Birth date	Marital status Single ☐ Married ☐ Widowed ☐ Divorced ☐
Residence address	City / State / Zip		Home phone
If child, parent's name or guardian's name			
Name of employer	Address		Business phone
Social security number	Driver's license		Occupation
Do you have medical insurance? ☐ Yes ☐ No	If no, how do you intend to pay? ☐ Check ☐ Cash ☐ Credit card		Ins. co. name & address
Subscriber name	Policy no.	Certificate no.	Is it through your employer? ☐ Yes ☐ No
Name of spouse	Birth date		Social Security number
Is there secondary ins., spouse 2nd carrier, etc.? ☐ Yes ☐ No	Name & address of spouse employer		Business phone
Secondary ins. name & address	Policy no.		Certificate no.
Medicaid no.	Medicare no.		
Workmen's compensation	Name of company		
Address of company	Company phone		Treatment authorized by
Person financially responsible for this account	Address		Relationship to Patient
Nearest friend or relative not residing with you	Relationship to patient		Phone
Whom may we thank for referring you?	Address		
What is your chief complaint?			

I authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for all charges, regardless of insurance coverage.

Patient, Parent, or Guardian Signature _____ Date _____