WELCOME to Sterling Family Dentistry, P. C.

DATE:_____

PATIENT NAME:_____

SOC. SEC. NO._____ DRIVER'S LICENSE:_____

BIRTH DATE:_____ AGE_____SEX: M F MARITAL STATUS_____

HOME ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL:_____

e-mail:_____

EMPLOYER NAME:_____

EMPLOYER STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

DENTAL INSURANCE? Y N

IF YES NAME OF INSURANCE CO._____

INSURANCE GROUP NO._____

RELATIONSHIP TO INSURED: SELF_____ SPOUSE_____ CHILD_____

- COMPLETE THE FOLLOWING INSURANCE INFORMATION ONLY IF THE INSURED IS SOMEONE OTHER THAN THE PATIENT.

INSURED'S NAME:_____

INSURED'S SOC. SEC. NO.:_____ DATE OF BIRTH:_____

INSURED'S EMPLOYER NAME:_____

EMPLOYER STREET ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

EMPLOYER PHONE_____

- IN CASE OF EMERGENCY PLEASE NOTIFY

NAME: PHONE:

WHOM MAY WE THANK FOR INVITING YOU TO VISIT US? _____