MICHAEL DYER DMD
FAMILY AND COSMETIC DENTISTRY

Patient Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ____-____-_____ Cell: ____-____-_____ Work: ____-____-_____

Male/Female DOB ___ - ___ - ____ Age: _____ Social Security #: _____-_____-_____

Drivers License# _____ E-Mail: _____@ _____

Employer: _____ Occupation: _____

City: _____ State:_____ Zip: _____ Phone: ____-____-_____

Emergency Contact: _____ Phone: ____-____-_____

Whom may we "**THANK**" for your referral: _____

Marital Status: (Circle One) **S M W D** Spouse Name: _____

Previous Dentist Name: _____ Phone: ____-____-_____

City: _____ State: _____ Date of Last Appt: _____

PERSON RESPONSIBLE FOR DENTAL ACCOUNT

Policy Holder's Name: _____ Relation: _____

Address: _____ City: _____ State:____ Zip: _____

Home Phone: ____-____-_____ Cell: ____-____-_____ Work: ____-____- _____

Male/Female DOB: ___ - ___ - _____ Age: _____ Social Security #:_____-_____- _____

Drivers License #:_____ E-Mail: _____@ _____

Employer: _____ Occupation: _____

City: _____ State:_____ Zip: _____ Phone: ____-____-_____

DENTAL INSURANCE POLICY(S) INFORMATION

PRIMARY INSURANCE: PLEASE PROVIDE OFFICE WITH DENTAL CARD(S) **INSURANCE COMPANY:** _____	
ID#	**GROUP#**
INSURED NAME	
ADDRESS	
CITY	**STATE**
POLICY HOLDERS NAME	
PAYOR ID	**EFFECTIVE DATE:**

Date: _____ **Signature:** _____