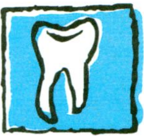

Winchester Dental

Providing gentle caring dentistry in a comfortable setting.

First Name________________ Last Name________________ Middle Initial______ Preferrred Name____________

Patient is: Policy Holder Responsible Party

Responsible Party (if someone other than patient)

First Name________________ Last Name________________ Middle Initial________

Address________________________________ City, State, Zip________________________

Home Phone________________ Work Phone________________ Ext________ Cell Phone____________

Birthdate________________ Social Security #________________ Employer________________

○ Responsible Party is also a Policy Holder for patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient information

First Name________________ Last Name________________ Middle Initial________

Address________________________________ City, State, Zip________________________

Home Phone________________ Work Phone________________ Ext________ Cell Phone____________

Birthdate____________ Age____ Social Security #________________ Drivers License #________________

Sex: ○ Female ○ Male Marital Status: single married widowed

E-mail________________________________ ○ I would like to receive correspondences via email

Section 2

Employment Status ○ Full Time ○ Part Time ○ Retired

Student Status ○ Full Time ○ Part Time

Preferred Pharmacy________________ Phone #__________

Preferred Hygienist________________________

Preferred Appointment Time ○ Morning ○ Afternoon

Section 3

Who referred you________________________

Best number to call________________________

Time to call you________________________

Emergency name________________________

Emergency number________________________

Primary Insurance

Name of insured________________________

Social Security #________________________

Employer________________________

Address________________________

City, State, Zip________________________

Relationship to insured ○self ○spouse ○child ○other

Insured birthdate________________________

Insurance Company________________________

Address________________________

City, State, Zip________________________

Secondary Insurance

Name of insured________________________

Social Security #________________________

Employer________________________

Address________________________

City, State, Zip________________________

Relationship to insured ○self ○spouse ○child ○other

Insured birthdate________________________

Insurance Company________________________

Address________________________

City, State, Zip________________________