Todd S. Klein, D.D.S. and Staff Welcomes You to Our Practice

Patient Information

(Please Print)

Date _____

Patient: _____
Last Name First Name Middle Initial

Street Address: _____

City: _____ State: _____ Zip: _____ TN License: _____ Exp: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex (M) ___ (F) ___ Age ____ Birthdate: _____ SS# _____

Married___ Widowed___ Single ___ Minor___ Separated___ Divorced____

Employer/School: _____ Employer Phone: _____

Employer/School Address: _____

E-Mail Address: _____

Pharmacy Name: _____ Phone Number: _____

Responsible Party Information

(IF DIFFERENT FROM PATIENT)

Responsible Party: _____ Relationship to Patient: _____

Birthday: _____ SS#: _____ M____ W___ S___ Sep____ D____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Street Address: _____

City: _____ State: ____ Zip: _____ TN License_____ Exp: _____

Employer/School: _____ Employer Phone: _____

Employer/School: Address: _____

Policy Holder Information

(Information On the Person That Carries The Insurance)

Insured Name: _____ Insured DOB: _____

Insured Employer: _____

Employer Address: _____ Phone: _____

Insured SS#: _____ Insured ID#: _____

Dental Insurance Company: _____ Group #: _____

In Case of Emergency, who should be notified? _____

Phone Number (____) _____ Whom may we thank for referring you? _____