Office Use Only
_______ Driver's License
_______ Insurance Card
_______ Staff Initials

Family Dental Care of Milford Prof. Assn.

K. Drew Wilson, DMD, MAGD ~ Joshua T. Osofsky, DMD
Amanda M. Smith, DMD, MPH ~ Ward Gravel, DDS, FAGD

PATIENT INFORMATION

Today's Date ________________________ DOB __________________ Male / Female (circle one)

Circle One Single Married Widowed Divorced **Preferred Doctor Dr. Wilson Dr. Osofsky Dr. Smith Dr. Gravel**

Patient Name ____ Preferred Name _________________
Last First MI

Primary Address ______________________________________ Cell Phone____

City/Town ____ Email ____

State _______________________ Zip ________________ Work Phone _______________________________________

Social Security Number_____________________________ Home Phone _______________________________________

Driver's License Number ___________________________

Additional contact person (not living with you) Name __________________________________ Phone _______________________

Whom may we thank for referring you to our office? ____

Do you have dental insurance? Yes or No

SUBSCRIBER INFORMATION (if different from above)

Subscriber Name ____ DOB___________________

Relationship to patient ____________________________

Social Security Number ___________________________ Driver's License Number ________________________________

Address (if different) ____Employer __________________________________

City/Town ____ Address ____

State _______________________ Zip ________________ State ____________________________ Zip _____________________

Cell Phone ____ Email ____

Home Phone_______________________________________ Work Phone____

INSURANCE INFORMATION

Insurance Company ____

Subscriber ID #____________________________________ Group Number ____________________

Phone Number for Insurance ______________________________

Address to send claim to ____

City ____________________ State ______________________ Zip _______________

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I have received a copy of the practice's *Notice of Privacy Practices.*

Signature____ Date___________________

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