Office Use Only
_____ 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 _____ Patient's DOB_____ Male / Female (circle one)

Preferred Doctor Dr. Wilson Dr. Osofsky Dr. Smith Dr. Gravel

Patient Name _____ Preferred Name _____
Last First MI

Primary Address _____ Primary Phone_____

City/Town _____ State _____ Zip _____

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

Do you have dental insurance? Yes / No (circle one)

PERSON RESPONSIBLE FOR PAYMENT TO BE MADE AT TIME OF SERVICE

Parent/Guardian 1_____ 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_____

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Parent/Guardian 2_____ 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_____

IF THERE IS DENTAL INSURANCE, PLEASE COMPLETE BOTH SIDES

SUBSCRIBER INFORMATION

Name of Subscriber ____ 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____________________

Parent or Legal Guardian

* *