

Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely.
The better we communicate, the better we can care for you.



ALLEN DENTAL CENTER, PA

A Family Tradition of Dental Excellence - Guaranteed

About You

Today's Date: _____ E-mail Address _____

Name: _____ I prefer to be called: _____ Male Female
Last First Mi Mr. Mrs. Ms. Dr.

Birthdate: ____/____/____ Age: _____ Social Security#: _____

Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Cell #: (____) _____

Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Would you be interested in being contacted via email? Yes No via texting? Yes No

Whom may we thank for referring you? Allen Image Allen Family Magazine Sign Website Yellow Pages Best of Allen

Care Enough to Share Brochure Patient or staff Member (Name: _____)

Other: _____

Other family member seen by us: _____

Employer: _____ How long there? _____ Occupation _____

Employer's Address: _____
Street City State Zip

RESPONSIBLE PARTY

Check here if the responsible party is the same as above.

His/Her Name: _____ Relation: _____

Work Phone #: (____) _____ Home Phone #: (____) _____

Social Security#: _____ Birthdate: ____/____/____ Cell Phone #: (____) _____

Address: _____
Street City State Zip

EMERGENCY CONTACT

His/Her Name: _____ Relation: _____

Phone #: (____) _____ Alternate Phone #: (____) _____

Address: _____
Street City State Zip

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone #: (____) _____

Group # (plan/Policy): _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birthdate: ____/____/____ Relation: _____

Insured's Employer: _____ Insured's ID #: _____