Family Dental Care
DOUGLAS LERNER, DDS
GARDNER, KANSAS

PATIENT INFORMATION

Date:_____

Patient Name_____Preferred Name_____
Sex: **M** or **F** Marital status_____DOB_____SS#_____
Address_____City_____St_____Zip_____
Home #_____Work #_____Cell#_____
Email_____

Primary Care Physician:_____**PCP tel#:**_____

IF PATIENT IS A MINOR:

Father's info:
Name_____DOB_____SS#_____
Address_____City_____St_____Zip_____
Hm #_____Cell #_____Wk #_____
Email_____
Employer_____Occupation_____

Mother's info:
Name_____DOB_____SS#_____
Address_____City_____St_____Zip_____
Hm #_____Cell #_____Wk#_____
Email_____
Employer_____Occupation_____

IF PATIENT IS AN ADULT:
Employer_____Occupation_____
Employer address_____City_____St_____Zip_____
Emp tel#_____

Spouse's info:
Name_____DOB_____SS#_____
Cell#_____Work#_____
Employer_____Occupation_____
Emp address_____City_____St_____Zip_____

PRIMARY DENTAL INSURANCE
Policy Holder_____DOB_____Relation to patient_____
Employer_____Insurance Company_____
ID#_____SS#_____Plan#_____

SECONDARY DENTAL INSURANCE
Policy Holder_____DOB_____Relation to patient_____
Employer_____Insurance Company_____
ID#_____SS#_____Plan#_____
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EMERGENCY CONTACT INFORMATION (other than parent or spouse)
Name_____Phone#_____
Relation to Patient_____

REFERRAL INFORMATION How did you hear about our practice?
___Advertisement___Internet___Ins___Drive-by
___friend/family member: name_____