RESTORATIVE, COSMETIC & FAMILY DENTISTRY

GREGSON & ASSOCIATES
DENTISTRY

JEFFREY
GREGSON, DDS

WELCOME!

Thank you for selecting our dental healthcare team!

We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask and we will be happy to help.

INFORMATION

Name (Full) _____ Nick Name / Preferred Name _____

Address _____ City _____ State _____ Zip _____

Home # _____ Cell # _____

Birthdate _____ SSN _____ E-mail: _____

CHECK WHICH ONE IS APPROPRIATE? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If a student, circle FULL OR PART-TIME NAME OF SCHOOL _____

Patient or Parent's Employer _____ Work # _____

Spouse Name _____ Employer _____ Work # _____

PERSON TO CONTACT IN CASE OF EMERGENCY

_____ Relationship _____ Phone # _____

WHO REFERRED YOU (HOW DID YOU HEAR ABOUT US?)

_____

RESPONSIBLE PARTY (IF OTHER THAN SELF)

Person Responsible for Account _____ Relationship _____

Address _____ Home # _____

Signature _____ SSN _____

DENTAL INSURANCE INFORMATION

Policy Holder _____ Birthdate _____ Relationship _____

Insurance Company _____ Phone # _____ Group # _____

Policy Holder SSN # _____ Policy Holder Member ID # _____

Name of Employer _____ City _____ State _____

I agree that this signature indicates that the above information is accurate.

Signature of Patient _____ Date _____