

Welcome to the office of Thomas R. Clark, DDS

This form was created to help our team learn more about you, your wishes and needs.
Please read through and complete each section which pertains to you. Thank you.

ABOUT YOU

PATIENT INFORMATION

Today's Date _____
How did you learn about our office? _____
(Please include the Name, Address & Phone # of your Referral Source. We would like to thank them for their support!).

Patient Prefers to be Called (Name and/or Title):

Patient's Legal Name:

Where does the Patient Live? (Address):

What address would you like to receive mail from us?

If mailing address is different than above: (Complete Below)
Please include Relationship to Patient, Name, Address,
Home & Work Phone #'s

Patients Home Phone # _____

Patients Work Phone # & ext. _____

Other Phone #'s _____

E-Mail Address _____

Do you check your email frequently? Yes or No

Date of Birth _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Full Time College Student? Where _____

Social Security # _____

Who is responsible for the Patients Account? _____

If Responsible Party is different than Patient: (Complete Below)
(Please include Name, Address, Home & Work phone #'s,
Employer, SS# & DOB)

Patients Employer: (Include Name, Address & Phone #)

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insured Parties Name _____

Relationship to Patient _____

Insured Address _____

Insured Home, Work & Other Phone #'s _____

Insured Date of Birth _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Insured Social Security # _____

Insured Employer _____

Insurance Plan Name, Group # &/or Contact:

Insurance Co. Name & Address _____

Insurance Co. Phone & Fax _____

SECONDARY DENTAL INSURANCE

Insured Parties Name _____

Relationship to Patient _____

Insured Address _____

Insured Home, Work & Other Phone #'s _____

Insured Date of Birth _____ Sex: Male Female

Marital Status: Single Married Divorced Widowed

Insured Social Security # _____

Insured Employer _____

Insurance Plan Name, Group # &/or Contact

Insurance Co. Name & Address _____

Insurance Co. Phone & Fax _____