

Kevn R. Draper, DDS - Garrett R. Draper, DDS

*We are committed to providing the highest quality dental care for you
in a manner that empowers you to have ongoing health throughout your life.*

PATIENT INFORMATION

Date _____

1) Name _____ Preferred Name _____

Address _____ Birthdate _____

city state zip Age _____ Male Female

Hm Phone () _____ Soc. Sec. # _____

Wk Phone () _____ Ext. _____

Cell Phone () _____ Single Married Divorced Widowed

FAX () _____ E-Mail _____

Full Time Student? YES NO School Name? _____

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

RESPONSIBLE PARTY / INSURANCE INFORMATION

2) Name _____ Relationship to patient _____

Residence _____ Birthdate _____
if different from patient's city state zip Soc. Sec. # _____

Hm Phone () _____

Employer _____ Wk Phone () _____ Ext. _____

Address street city state zip _____

Primary Insurance _____ Group # _____

Insurance Co. Address _____ Phone # _____

3) Spouse _____ Relationship to patient _____

Wk Phone () _____ Ext. _____ Birthdate _____

Employer _____ Soc. Sec. # _____

Address street city state zip _____

Secondary Insurance _____ Group # _____

Insurance Co. Address _____ Phone # _____

EMERGENCY CONTACT

Whom may we notify in case of emergency?

4) Name _____

Hm Phone () _____

Wk Phone () _____ Ext. _____

Please Complete Both Sides