DDL Dental

"Oral Health Means Total Health"

Thank you for visiting Tempe Dental Care. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Address _____
STREET APT #

_____
CITY STATE ZIP

Employer _____ Driver License _____

Birth Date _____ ☐ Married ☐ Single ☐ Other

Height _____ Weight _____ ☐ Male ☐ Female

Phone: Home (_____)_____ Social Security # _____

Work (_____)_____

Cell (_____)_____ Email _____

Emergency Contact: Name_____ Phone (_____)_____

How did you hear about us? ☐ Yellow Pages ☐ Google ☐ Yahoo ☐ DexKnows ☐ Walk in/Drive by ☐ Insurance ☐ Mailer

☐ Referred By: _____ ☐ Other_____

Insurance

Primary Dental Carrier

Insurance Co Name: _____ Phone #: _____

Insured's Name: _____ Birth Date: _____ ID#: _____

Insured's Employer: _____ Group #: _____

Relationship to Patient: _____

Secondary Dental Carrier

Insurance Co Name: _____ Phone #: _____

Insured's Name: _____ Birth Date: _____ ID#: _____

Insured's Employer: _____ Group #: _____

Relationship to Patient: _____

If Patient Is Under 18 Years Of Age

Responsible Party _____ Relation to Patient _____

Address _____
STREET CITY STATE ZIP

The information on this page is correct to the best of my knowledge

_____ _____
PATIENT OR PARENT/GUARDIAN **SIGNATURE** DATE

_____
PATIENT OR PARENT/GUARDIAN **SIGNATURE**