Kenneth G. Wallis DDS

Family and Cosmetic Dentistry

Patient Information

Patient Name:______________________________ Date of Birth: ______________

Address:______________________ City:______________ State:______ Zip: ________

Phone: ______________________ Email: ______________________

Sex: Male or Female Marital Status:______________ Social Security #:______________

Occupation:_ ______________________ Employer: ______________________

Employer Address:_ ______________________________

Are you under 18? YES / NO If yes, list parents/guardian: ______________________

Emergency Contact:______________ Relation to Patient:______________________

Address: ______________________________ Phone:______________________

Dental Benefit Information

Primary Dental Plan Name: ______________________________

Name of Insured:______________________ Insured DOB:______________________

Insurance ID: ______________________________

Policy Number: ______________________________

Relation to Insured: ______________________________

Secondary Dental Plan Name: ______________________________

Name of Insured:______________________ Insured DOB:______________________

Insurance ID: ______________________________

Policy Number: ______________________________

Relation to Insured: ______________________________

How Did You Hear About Us? Circle what applies.

Referral Website Advertisement YELP Dental Benefits Other