LISA GITELSON, DMD, PC
DAVID L. WILSON, DMD
14300 S.W. PACIFIC HWY.
TIGARD, OR 97224

PATIENT INFORMATION

Welcome to our office! Please fill out this form completely in ink. All information is kept confidential. If you have any questions or need assistance, please ask us – we will be happy to help.

Patient's Name:____ Today's Date_________________

Preferred Name: ______________________ Male / Female Age:______ Birthdate:_____________

Address:____

City:_______________________________________ State:______________ Zip:________________

Home Phone:__________________Work Phone:___________________ Cell Phone:__________________

E-mail:____ Soc. Sec.#______________________________

Employer:______________________________ Address:______________________________________

If full time student, name of school______________________ Name of Spouse or Parent:______________

Person responsible for payment:____

Family members who have been patients here:____

Nearest relative NOT living with you:___________________________ Phone:______________________

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

Previous Dentist:________________________________ Address:________________________________

Insurance Company:______________________________________ Phone:________________________

Address:____

Insured:_____________________________ Birth Date:______________ I.D. #_______________

Relationship to Insured:_____________ Employer:__________________ Group Number:_____________

Secondary Insurance Company:_______________________________ Phone:_______________________

Address:____

Insured:_____________________________ Birth Date:____________ I.D. #_______________

Relationship to Insured:_____________ Employer:__________________ Group Number:_____________