LISA GITELSON, DMD, PC
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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:_____