LISA GITELSON, DMD, PC
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:_____________