Dr. Jacob Berger, D.D.S.

Family and Cosmetic Dentistry

Fill this form before printing, then sign the hard copy. Print

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

(1) IF THIS APPOINTMENT IS FOR YOU START HERE

DATE:

NAME:

SPOUSE:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE #:

BIRTHDATE: AGE:

MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐

IF THIS APPOINTMENTS IS FOR YOUR CHILD START HERE

DATE:

NAME:

ADDRESS:

CITY: STATE: ZIP:

HOME PHONE #:

BIRTHDATE: AGE: GRADE:

SCHOOL:

If your child's name and address are not the same as yours, fill in the above box also.

(3) ACCOUNT INFORMATION

Person responsible for account:

Driver's License #:

S.S. #:

YOUR

Name:

Occupation:

Employer:

Business Address: City:

Business Telephone: Ext:

YOUR SPOUSE

Name:

Occupation:

Employer:

Business Address: City:

Business Telephone: Ext:

(2) INSURANCE

PRIMARY CARRIER

Insurance Co.:

Employee:

Union or Local #:

Group #:

Badge #:

Date Employed:

Social Security:

SECONDARY CARRIER

Insurance Co.:

Employee:

Union or Local #:

Group #:

Badge #:

Date Employed:

Social Security #:

(4) GETTING TO KNOW YOU

Is another member of your family, or relative a patient at our office?

Referred to us by:

Former Address:

Person to contact for emergency:

Phone:

Address:

Closest relative not living with you:

Phone:

Address:

CONCERNS: