LEAVITT FAMILY AND COSMETIC DENTISTRY

Attention to Detail Makes All the Difference

Patient Information

Patient Name_____ Sex____ Age____ Patient Birthdate_____

Home Phone #_____ Cell Phone #_____

Home Address_____ City, State, Zip_____

Social Security #_____ Email_____

Employer_____ Employer Phone #_____

Spouse_____ Birthdate_____ Cell Phone #_____

Spouse Employer_____ Phone #_____

Emergency Contact _____ Phone #_____

Physician Name_____ Phone #_____ Last Physical_____

Former Dentist_____ Orthodontist_____

Whom May We Thank for Referring You?_____

What is your main dental concern?_____

Responsible Party

Name_____ Relationship_____ Phone #_____

Address_____ City, State, Zip_____

Primary Insurance

Insurance_____ Phone #_____ Group #_____

Employer_____ ID#_____ PolicyHolder SS# _____

PolicyHolder_____ Date of Birth_____ Phone #_____

PolicyHolder Address_____ City, State, Zip_____

Secondary Insurance

Insurance_____ Phone #_____ Group #_____

Employer_____ ID#_____ PolicyHolder SS# _____

PolicyHolder_____ Date of Birth_____ Phone #_____

PolicyHolder Address_____ City, State, Zip_____