Draper Family Dentistry

Kevin R. Draper, DDS
Garrett R. Draper, DDS

We are committed to providing the highest quality dental care for you in a manner that empowers you to have ongoing health throughout your life.

PATIENT INFORMATION

Date ______

1) Name ______ Preferred Name ______

Address ______ Birthdate ______

city state zip

Age ______ ☐ Male ☐ Female

Hm Phone ( ) ______ Soc. Sec. # ______

Wk Phone ( ) Ext. ______ **E-Mail** ______

(for appointment confirmation only)

Cell Phone ( ) ______

FAX ( ) ______ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Full Time Student? ☐ YES ☐ NO School Name? ______

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

Have you seen us on: **Draper Family Dentistry website** Y / N **Yelp** Y / N **Google** Y / N **Facebook** Y / N **YP.Com** Y / N

RESPONSIBLE PARTY / INSURANCE INFORMATION

2) Name ______ Relationship to patient ______

Residence ______ Birthdate ______

if different from patient's — city state zip ______ Soc. Sec. # ______

Hm Phone ( ) ______

Employer ______ Wk Phone ( ) Ext. ______

Address street city state zip ______

Primary Insurance ______ Group # ______

Insurance Co. Address ______ Phone # ______

3) Spouse ______ Relationship to patient ______

Wk Phone ( ) Ext. ______ Birthdate ______

Employer ______ Soc. Sec. # ______

Address street city state zip ______

Secondary Insurance ______ Group # ______

Insurance Co. Address ______ Phone # ______

EMERGENCY CONTACT

Whom may we notify in case of emergency?

4) Name ______

Hm Phone ( ) ______

Wk Phone ( ) Ext. ______

~ Please Complete Both Sides ~