Texas Periodontists
periodontics and dental implants

Personal

First Name ________________________ Last Name ___________________________ Preferred Name ____________

Sex [ ] M [ ] F Marital Status [ ] Married [ ] Single [ ] Other

Address: ____ City ______________________ State ______ Zip ________

Home Phone _______________________ Cell Phone _______________________ Work Phone _________________

Email ____

Birth Date __________________ Soc. Sec # _______________________ Driver's License # ____________________

Occupation ____ Employer ______________________________

Preferred Contact method [ ] Phone [ ] Email [ ] Text

Preferred Contact method for confirmations [ ] Phone [ ] Email [ ] Text

Dental Insurance

Your relationship to Subscriber [ ] Self [ ] Spouse [ ] Child

Subscriber Name ____ Subscriber ID # ___________________________

Insurance Company _____________________________________ Insurance Company Ph. ____________________

Employer Name ______________________________ Group # __________________ Group Name _______________

Please present insurance card at your visit. If you have dual insurance, please provide info for your secondary carrier.

Emergency Information

Emergency Contact Name ____________________________________ Emergency Contact Ph. _________________

Relationship to Emergency Contact ____________________________________

Physician Name _______________________________________ Physician Phone _______________________

Pharmacy Name ______________________________ Pharmacy Location/ Intersection _________________________

Pharmacy Phone Number _________________________________

Referral

Referring Dentist Name ___________________________________ Referring dentist Ph. ____________________

For self-referred only: How did you hear about us?

[ ] Insurance Website [ ] Google [ ] Website [ ] Family member