BOILING SPRINGS DENTISTRY
MARK G. FLETCHER, DMD
AND ASSOCIATES

Date: _____

PATIENT INFORMATION

Patient Name: First_____ MI: _____ Last: _____

DOB: _____ Driver's License #: _____

Sex: Male / Female SSN: _____ Marital Status: _____

Address: _____ City: _____State/Zip: _____

Email: _____ Home #: _____ Cell: _____

I would like to receive communications by (circle all that apply): TEXT / EMAIL / VOICEMAIL / MAIL

Previous Dentist: _____ Referred By: _____

Emergency Contact: _____ Relationship: _____Phone #: _____

Responsible for Account: SELF / OTHER: _____ Relationship: _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber Name: First_____ MI: _____ Last: _____

DOB: _____ Relationship to Patient: SELF / Spouse / Child / Other: _____

Subscriber's Address (if different)_____ City/State/Zip: _____

SSN of Subscriber: _____ ID#: _____ Group #: _____

Name of Employer: _____

Name of Ins. Company: _____ Phone #: _____

Ins Co Address: _____ City/State/Zip: _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber Name: First_____ MI: _____ Last: _____

DOB: _____ Relationship to Patient: SELF / Spouse / Child / Other: _____

Subscriber's Address (if different): _____ City/State/Zip: _____

SSN of Subscriber: _____ ID#: _____ Group #: _____

Name of Employer: _____

Name of Ins. Company: _____ Phone #: _____

Ins Co Address: _____ City/State/Zip: _____