



**MICHAEL DYER**  
FAMILY AND COSMETIC DENTISTRY **DMD**

Patient Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Male/Female DOB \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
 Drivers License# \_\_\_\_\_ E-Mail: \_\_\_\_\_@\_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Whom may we "THANK" for your referral: \_\_\_\_\_  
 Marital Status: (Circle One) **S M W D** Spouse Name: \_\_\_\_\_  
 Previous Dentist Name: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Date of Last Appt: \_\_\_\_\_

**PERSON RESPONSIBLE FOR DENTAL ACCOUNT**

Policy Holder's Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell: \_\_\_\_-\_\_\_\_-\_\_\_\_ Work: \_\_\_\_-\_\_\_\_-\_\_\_\_  
 Male/Female DOB: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_-\_\_\_\_  
 Drivers License #: \_\_\_\_\_ E-Mail: \_\_\_\_\_@\_\_\_\_\_  
 Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_-\_\_\_\_-\_\_\_\_

**DENTAL INSURANCE POLICY(S) INFORMATION**

<b>PRIMARY INSURANCE: PLEASE PROVIDE OFFICE WITH DENTAL CARD(S)</b>	
<b>INSURANCE COMPANY:</b> _____	
<b>ID#</b>	<b>GROUP#</b>
<b>INSURED NAME</b>	
<b>ADDRESS</b>	
<b>CITY</b>	<b>STATE</b>
<b>POLICY HOLDERS NAME</b>	
<b>PAYOR ID</b>	<b>EFFECTIVE DATE:</b>

Date:

Signature: