SMILE SOLUTIONS

WILLIE CANTU D.D.S

Returning Patient Information

For your welfare and our efficiency of diagnosis, treatment and billing, please fill out this confidential form completely. Please answer ALL questions. If a question does not apply, please mark N/A in the blank. Thank you.

Patient Information:

Date: _____

❍ Mr. ❍ Mrs. ❍ Miss ❍ Dr. First Name: _____ Last Name: _____

Marital Status: ❍ Married ❍ Single ❍ Divorced ❍ Widowed ❍ Legally Separated Age: _____

Email: _____ Phone #: _____ Cell #: _____

Address: _____ City/State/Zip: _____

Employer: _____ Work #: _____

Student: ❍ Yes ❍ No ❍ FT ❍ PT School Name/Address: _____

Physician: _____ Phone #: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Dental Insurance Information: Primary

Policy Holder: _____ DOB: _____ Relationship to Patient: _____

Insurance Co. Name & Address: _____

Phone #: _____ Subscriber #: _____ Group #: _____

Any changes in your health history or medications since your last visit with us?

_____

Signature of Patient or Gardian