James J. Flaggert III, D.D.S.

PATIENT INFORMATION FORM

Today's Date:_____

Have you come to see us in the past? Y N

First Name_____ Middle Initial:___ Last Name :_____

Sex: M F Date of Birth:_____ Age:_____ Social Security No._____

Address:_____ City:_____ State:_____ Zip Code:_____

Home telephone # (_____) _____ Other telephone # (_____) _____

Employer:_____ Student: FT PT

Whom may we thank for referring you to our office:_____

Who will be responsible for account?_____ Relation: Self Spouse Mother Father

Name:_____ Telephone #_____

Street:_____ State:_____ Zip:_____

Dental Insurance Company:_____

Insurance Address:_____

Insurance telephone #_____

Policy/Group #:_____ ID#:_____

Name of Policy Holder:_____

Patient Relation to Policy Holder:_____

Policy Holder Address:_____

Policy Holder SS#:_____ Policy Holder Date of Birth:_____

Policy Holder Employer:_____

Medical Insurance Company:_____

Insurance Address:_____

Insurance Telephone # _____

Policy/Group #:_____ ID#:_____

Name of Policy Holder:_____

Patient Relation to Policy Holder:_____

Policy Holder Address:_____

Policy Holder SS#:_____ Policy Holder Date of Birth:_____

Policy Holder Employer:_____