

Welcome to the office of David J. Balkon, D.D.S.

PATIENT'S INFORMATION

Name: _____ Date of Birth: _____

Sex: (Please circle) ^(First) Male ^(Middle Initial) Female Marital Status: ^(Last) (Please circle) Single Married Divorced Widowed

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile #: _____

Social Security #: _____ Driver's License State & #: _____

Email Address: _____

Employer: _____ Employer's Phone #: _____

Employer's Address: _____

PARENT OR GUARDIAN INFORMATION

Please complete if patient is a minor (under the age of 18 years old)

Name: _____

Date of Birth: _____ Social Security #: _____

Home Phone #: _____ Mobile #: _____

Employer: _____ Employer's Phone #: _____

DENTAL INSURANCE INFORMATION

Please allow us to make a copy of your card(s)

Policyholder's Name: _____ Date of Birth: _____

Relationship to Patient: _____

Policyholder's ID # or SS #: _____ Group #: _____

Insurance Company Name & Phone #: _____

Secondary Insurance: Please ask for additional sheet if you have a secondary dental insurance plan

EMERGENCY CONTACT/SPOUSE INFORMATION

Emergency Contact Name & Phone #: _____

Spouse's Name & Phone # if not listed above: _____

Please circle your preferred methods of appointment reminders. You may select as many as you wish.

Phone calls Text messages E-mails Post cards

I acknowledge that I have been provided a copy of the Privacy Policy

Signature of Patient, Parent or Guardian: _____ Date: _____