Fairfield Oral Surgery and Implantology

Date ____________________

PATIENT INFORMATION

Have you ever been seen in our office before? ❒ Yes ❒ No

Patient Name ____________________

Address ____________________
Patient's place of residence - no PO boxes please.

City, State, Zip ____________________

Home Phone ____________________ Cell Phone ____________________

Work Phone ____________________

Birthdate ____________________ Age _____ ❒ Male ❒ Female

SSN# ____________________

Driver's License # ____________________

Are you a full-time student? ❒ Yes ❒ No

If yes, name of school attending? ____________________

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SPOUSE INFORMATION

Name ____________________

Occupation ____________________

Employer ____________________

Work Address ____________________

City, State, Zip ____________________

Cell Phone ____________________ Work Phone ____________________

PARENT INFORMATION *(for patient 18 years or younger)*

Father's Name ____________________

Address ____________________

City, State, Zip ____________________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________

Birthdate __________ SSN# ____________________

Employer ____________________

Work Address ____________________

City, State, Zip ____________________

Occupation ____________________

Mother's Name ____________________

Address ____________________

City, State, Zip ____________________

Home Phone ____________________ Work Phone ____________________

Cell Phone ____________________

Birthdate __________ SSN# ____________________

Employer ____________________

Work Address ____________________

City, State, Zip ____________________

Occupation ____________________

REFERRED BY ____________________ **GENERAL DENTIST** ____________________

INSURANCE INFORMATION	Primary Dental	Secondary Dental	Medical Insurance
Insured Employee			
Social Security #			
Date of Birth			
Employer			
Group/Policy/Medical Record # ***(need Kaiser # for patient)***			
Name of Insurance			

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