



COOPER, BAILEY, FRASER, & HUANG D.D.S., P.A.

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out these forms completely. The better we communicate, the better we can care for you.

TODAY'S DATE: _____

ABOUT YOU:

Name: _____
Last First MI (Mr. Mrs. Ms. Dr.)

Home Address: _____

City State Zip Apt/Condo#

Home phone #: _____ Wk. phone #: _____ Ext. _____ Cell #: _____

MALE FEMALE BIRTHDATE ____/____/____ AGE: ____ SS#: ____/____/____

Single Married Divorced Widowed Separated DL# _____ Exp. Date _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____ Where & when are the best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us? _____

Previous/Present Dentist (please circle one): _____ Last Visit Date: _____

SPOUSE INFORMATION:

Name _____

Employer: _____ Wk. Phone #: _____ Ext. _____

SS#: ____/____/____ Birthdate: ____/____/____ DL#: _____ Exp. Date _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Billing Address: _____

Relationship: _____ SS#: ____/____/____

Employer: _____ DL# _____ Exp. Date _____

DENTAL INSURANCE:

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS#: _____

Insured's Employer _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ____/____/____ Insured's SS#: _____

Insured's Employer _____

EMERGENCIES:

In the event of an emergency, who may we contact? _____

Relation to you: _____ Home phone# _____ Work phone # _____