

**WELCOME**  
**MERTZ FAMILY DENTISTRY**

***Patient Information***

**Name:** \_\_\_\_\_ **Male**  **Female**   
First MI Last (circle) Mr. Mrs. Ms Dr. (Name you prefer to be called)

**Birth date:** \_\_\_/\_\_\_/\_\_\_ **Age:** \_\_\_  Single  Married  Divorced  Widowed

**Home Address:** \_\_\_\_\_  
Street City State Zip

**Mailing Address (If different)** \_\_\_\_\_  
Street City State Zip

**Home Phone #** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Work** \_\_\_\_\_

**What phone number do you prefer us to call you at?** \_\_\_\_\_

**Who may we thank for referring you?** \_\_\_\_\_

**Other family members seen by us?** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Employer Address:** \_\_\_\_\_  
Street City State Zip

**Emergency Contact:** \_\_\_\_\_  
Name Phone Relation

**SPOUSE INFORMATION**

**His / Her Name:** \_\_\_\_\_ **Birth date:** \_\_\_/\_\_\_/\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone#** \_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY DENTAL INSURANCE COVERAGE**

**Insurance Co. Name:** \_\_\_\_\_ **Phone # :** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Insured's Birth date:** \_\_\_/\_\_\_/\_\_\_

**Insured's Employer:** \_\_\_\_\_ **Employer's Address:** \_\_\_\_\_

**Secondary Insurance**

**Insurance Co. Name:** \_\_\_\_\_ **Phone # :** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Insurance Co. Address:** \_\_\_\_\_

**Insured's Name:** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Insured's Birth date:** \_\_\_/\_\_\_/\_\_\_

**Insured's Employer:** \_\_\_\_\_ **Employer's Address:** \_\_\_\_\_