Lewelling Dental Care
Personalized & Comfortable

Today's Date:

A MESSAGE FROM DR. SHITAL KAZI

"Thank you for choosing Lewelling Dental Care. My staff and I welcome you to our practice. I assure you that you will get an advanced and quality dental care and the best services. To help us serve you better, please complete the following form. You will have to provide the information only once and that will save you a significant time in your subsequent visits. If you have any questions please do not hesitate to ask for help. I look forward to meeting you."

PATIENT INFORMATION *(Please write information about the patient here)*

PATIENT'S NAME (Last, First, Middle Initial) Sex: □ Male □ Female	EMPLOYER'S NAME
PATIENT'S ADDRESS	EMPLOYER'S ADDRESS TELEPHONE ( )- -
CITY STATE ZIP	CITY STATE ZIP
TELEPHONE ( ) MARITAL STATUS □ Single □ Married □ Separated □ Divorced □ Widowed DATE OF BIRTH ____/____/____ MM DD YY	EMPLOYMENT STATUS □ -Full Time □ -Part Time □ -Retired □ -Not Employed STUDENT STATUS: If 19 Years or older □ -Full Time □ -Part Time □ -Not a Student
AGE SOCIAL SECURITY NUMBER DRIVERS LICENSE NUMBER PAGER/ CELL PHONE	E-MAIL

INSURANCE INFORMATION *(Please write information about the patient's insurance here)*

PRIMARY INSURANCE COMPANY NAME	SECONDARY INSURANCE COMPANY NAME
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER

RESPONSIBLE PARTY INFORMATION
POLICY HOLDER INFORMATION

(Please complete if the PATIENT is NOT the Policyholder)

Is secondary policy holder: □ Patient □ Primary Policy Holder □ Other
(Complete the information below if you checked "Other")

PRIMARY POLICY HOLDER'S NAME (Last, First, MI) Date of Birth ____/____/____ MM DD YY	SECONDARY POLICY HOLDER'S NAME (Last, First, MI) Date of Birth ____/____/____ MM DD YY
PRIMARY POLICY HOLDER'S ADDRESS SEX: □ Male □ Female	SECONDARY POLICY HOLDER'S ADDRESS SEX: □ Male □ Female
CITY STATE ZIP TELEPHONE ( ) -	CITY STATE ZIP TELEPHONE ( ) -
SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT □ Spouse □ Patient □ Other ____	SOCIAL SECURITY NUMBER RELATIONSHIP TO PATIENT □ Spouse □ Patient □ Other ____
EMPLOYER'S NAME	EMPLOYER'S NAME
EMPLOYER'S ADDRESS	EMPLOYER'S ADDRESS
CITY STATE ZIP TELEPHONE ( ) -	CITY STATE ZIP TELEPHONE ( ) -

IN CASE OF EMERGENCY CONTACT

NAME (Last, First, MI) RELATIONSHIP
ADDRESS
CITY STATE ZIP CITY
TELEPHONE: DAY: ( ) - EVENING:( ) -

YOUR PREFERENCES

PREFERRED TIME AND WEEK DAY FOR APPOINTMENT: TIME: DAY:
PREFERRED TIME AND PLACE TO CALL: TIME: □ Home □ Work
In case of availability do you want us to put you on an early call list? □ Yes □ No
HOW DID YOU HEAR ABOUT US?

I hereby give LDC permission to share this information, perform dental treatment, and use my records (all media types) for diagnostics, treatment, and study purposes.

_____ Date: _____
SIGNED (Patient, or parent if under 18 years of age) MM / DD / YY