

Dr. Sheila Dobe's Welcome Form

Today's Date ___/___/___ Whom may we thank for referring you to us? _____

Patient's Name: First _____ Middle _____ Last _____

Address: Number and Street _____

City _____ State _____ Zip Code _____

Email Address _____ @ _____

Home Phone _____ / _____ Cell Phone _____ / _____

Patient's Birthdate ___/___/___ Social Security Number _____ - _____ - _____

Employer _____ Work Phone _____ / _____

Full Time College Student? Y/N Name & City of School _____

Insurance Information

Insurance Carrier _____ **Insurance Phone Number** _____ / _____

Subscriber's Name: Last, First _____ Birth date ___/___/___

Social Security Number _____ - _____ - _____ Subscriber ID# _____

Group Number _____ Group/Employer Name _____

Privacy Protection

Please list the names and phone numbers of family members or significant others, whom we may discuss your general dental condition. *including treatment, payment and health care operations:

Please list the names and phone numbers of family members or significant others, whom we may inform about your medical condition ONLY IN AN EMERGENCY.

Can we send your recall postcard to the address above without enclosing it in an envelope marked "Confidential"?

YES _____ NO _____

Can we send all other correspondence from our office without enclosing it in an envelope marked "Confidential"?

YES _____ NO _____

Can you receive calls on and voice messages on the phone numbers provided above?

YES _____ NO _____

Patient Signature _____ Date _____