Dr. Bennett Lax D.D.S.
Dr. G. Jeffrey Glikes D.D.S.

Soc. Sec. #: ____________

Patient Information (CONFIDENTIAL)

Date ____________

Name ____________ Birthdate ____________ HomePhone ____________

Address ____________ City ____________ State ______ Zip ____________

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School / College ____________ City ____________ State ______ ☐ Full Time ☐ Part Time

Patient's or Parent's Employer ____________ Work Phone ____________

Business Address ____________ City ____________ State ______ Zip ____________

Spouse or Parent's Name ____________ Employer ____________ Work Phone ____________

Whom May We Thankfor Referring You? ____________

Person to Contact in Case of Emergency ____________ Phone ____________

Responsible Party

Name of Person Responsible for this Account ____________ Relationship to Patient ____________

Address ____________ Home Phone ____________

Driver's License # ____________ Birthdate ____________ Financial Institution ____________

Employer ____________ Work Phone ____________ SSN# ____________

Is this Person Currently a Patient our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Secunty # ____________ Date Employed ____________

Name of Employer ____________ Union or Local #: ____________ Work Phone ____________

Address of Empkyer ____________ City ____________ State: ____________ Zip ____________

InsuranceCompany ____________ Group ____________ -policy/ID# ____________

Ins. Co. Address ____________ City ____________ State ______ Zip ____________

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured ____________ Relationship to Patient ____________

Birthdate ____________ Social Security # ____________ Date Employed ____________

Name of Employer ____________ Union or Local # ____________ Work Phone ____________

Address of Employer ____________ City ____________ State ______ Zip ____________

Insurance Company ____________ Group # ____________ Policy/11) # ____________

Ins. Co. Address ____________ City ____________ State ______ Zip ____________