Cumberland
FAMILY DENTISTRY
PLLC

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In order to help us render the proper dental services to you, would you please be kind enough to answer the following questions. Thank you for your cooperation.

Patient Information

First Name _____ MI _____ Last Name _____ Preferred Name _____

Birth Date _____ Age _____ Weight _____ SSN _____

☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

Email _____ How would you like to be contacted? ☐ Phone Call ☐ Text ☐ Email

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired **Student Status:** ☐ Full Time ☐ Part Time

Person To Contact In Case of Emergency: _____ Phone Number _____

I Learned of your Office By: ☐ Referred by _____ ☐ Office Sign ☐ Website ☐ Facebook ☐ Other

Patient is: ☐ Policy Holder

☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name _____ Last Name _____ Preferred Name _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Cell _____ Work _____

Primary Insurance Information if applicable

Name of Insured _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer _____ Insurance Company _____

Policy Number _____ Group Number _____

Phone Number _____ Birth Date _____ SSN _____

Secondary Insurance Information if applicable

Name of Insured _____ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Employer _____ Insurance Company _____

Policy Number _____ Group Number _____

Phone Number _____ Birth Date _____ SSN _____