

GENTLE DENTAL CARE

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Family Practice

Date_____

Patient's Name _____
Last First M.I.

Email address _____

Birthdate_____ Sex: M F

Name of Spouse_____ Spouse Birthdate_____

If a child, parent's name_____

Home Address_____

City_____ State_____ Zip_____

Home Phone_____ Business Phone_____

Patient's Employer_____

Present Position_____

Spouse's Employer_____ Phone_____

Referred by:_____

Who will pay this account_____

Method of payment (circle one) CASH CHECK VISA MC DISCOVER

Patient's Social Security Number_____

Spouse's Social Security Number_____

Drivers License Number_____ State_____

Nearest friend/relative not living with you_____

Relationship_____ Phone_____

DENTAL INSURANCE INFORMATION

Insured's Name_____ Employer_____

Insurance Co. Name & address_____

Group Number_____ ID # or SS# _____