WELCOME

The benefits of a happy healthy smile are immeasurable! Our Goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you

Dr. Harvinder S. Chadda
Family Dentistry Date_____

Patient Information

Patient Name: Last _____ First_____MI_____

____Male ____Female _____Married ____Single ____Child ____Other

SS#_____ Date of Birth_____

Phone (h) _____(w)_____(c)_____

E-Mail Address_____

Address_____

City _____ State _____ Zip Code _____

Employer Name_____ Phone #_____

In Case of Emergency: Name_____ Phone _____

Do you prefer being contacted by phone or by e-mail message or text?

Responsible Party Information

****This information is for whom ever is responsible financially for this patient and their treatment.**

Last _____ First _____ MI _____

__Male __Female SS# _____Date of Birth _____

Phone (h) _____ (w) _____ (c) _____

Address_____

City _____ State _____ Zip Code _____

Insurance Information

Policyholder

Last _____ First _____ MI _____

Address_____

City _____ State _____ Zip Code _____

SS# of Policyholder_____ Date of Birth_____

Patient's relationship to policyholder _____

Insurance Company Name_____ Phone #_____

Referral Information

Whom may we thank for referring you to our practice?

Another Patient, relative _____ Dental Office _____

Walk in_____Other_____Yellow Pages (which phonebook) _____