

THADDEUS S. MICHALSKI D.M.D.

GENERAL, COSMETIC AND IMPLANT DENTISTRY

Blending the Art & Science of Dentistry

So that we may provide the best of care, please fill out both sides of these forms completely

Patient Information

Last Name: _____ First Name: _____ MI: _____ Date: _____

Nickname/Preferred Name: _____ Birth Date: ____ / ____ / ____ Male Female

Married Single Child Other _____ If married, name of spouse: _____

SS # _____ Driver's License # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Ext: _____ Best time to call: _____

Mobile/Cell: _____ Email: _____

How do you prefer for us to confirm your visits: Email Cell Home Work Other: _____

Occupation: _____ Employer: _____

Do we have your permission to contact you at work if necessary? Yes No

Responsible Party Information (If different from above)

Last Name: _____ First Name: _____ MI: _____ Date: _____

Relationship to patient: _____ Birth Date: ____ / ____ / ____ Male Female

Married Single Child Other _____ If married, name of spouse: _____

SS # _____ Driver's License # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Work: _____ Ext: _____ Best time to call: _____

Mobile/Cell: _____ Email: _____

Occupation: _____ Employer: _____

Referral Information

Whom may we thank for referring you to our practice? Another patient Dental Office Yellow Pages

Newspaper Mailer Work Other: _____

Name of person or office referring you to our practice: _____

Primary Dental Insurance Information

Name of Insured: _____ Birth Date: ____ / ____ / ____
Last First MI

Relationship to patient: _____ ID # _____ Group # _____

Insurance Plan Name: _____ Phone: _____

Insurance Plan Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Please complete **BOTH** sides →

