BENNINGTON DENTAL CENTER

Family and Cosmetic Dentistry

Thank you for selecting our dental health team. We look forward to working with you in maintaining your dental health.

Patient Information:	pate:						
Patient Name:							
Birth Date: Male:	Female:	Single: M	farried:	Other	:_Minor:	YN	
SS#:	Drivers Li	Orivers License #: City: State: Zip: Cell#: Work#: Best way to reach you:					
Address:	City:		Sta	te:	Zip:		
Home Phone#:	Cell#:		Worl	κ#:			
Email Address:		Best way	to reach	you:	HP		
Employer:							
Emergency Contact:		Phone #:					
Other family members seen by us?							
How did you hear of us?							
How did you hear of us?	ve thank fo	or the referra	1?				
Parent/Guardian information (if p			4				
Name:	Relationship to patient: Drivers License#:						
Birth Date:SS#:	O''	Drivers License#:		toto.	7im.		
Address:	Call	_City:		StateZip			
Home Phone#:	_Cell#:		VV	OFK#:_			
Email Address:							
Dental Insurance Information (Pri	imary):						
Policyholder's Name:		Birth Date:		5	SS#:		
Insurance Company:		Group#:					
Employer:		Policyholders ID#:					
Patient Relationship to Policyholder							
Dental Insurance Information (Se	condary):						
Policyholder's Name:		Birth Date:			SS#:		
Insurance Company:		Group#:					
Employeer:		Policyholders ID#:					
Employeer: Patient Relationship to Policyholder	: Self:	_Child:	_Other:				