



**Stockbridge
Dental
Care, PC**

Welcome to Dr. Felcher's Office

ABOUT YOU

Today's Date: _____

Patient's Name: _____ MALE FEMALE

Address: _____ Apt #: _____ City: _____ Zip: _____

Email Address: _____

Home Phone #: _____ Cell #: _____ Birth date: ___/___/___

Other members of your family seen by our office? _____

Emergency Contact: _____ Phone #: _____

IF PATIENT IS AN ADULT

Employer: _____

Spouse's Name: _____

Position: _____

Employer: _____

Phone #: _____

Phone #: _____

Social Security #: _____

Social Security #: _____

IF PATIENT IS A CHILD

Father's Name: _____

Mother's Name: _____

Address (if different from above): _____

Address (if different from above): _____

Date of Birth: ___/___/___ SS #: _____

Date of Birth: ___/___/___ SS #: _____

Employer: _____

Employer: _____

Position: _____

Position: _____

Phone #: _____

Phone #: _____

DENTAL INSURANCE

Primary Ins. Co.: _____

Secondary Ins. Co.: _____

Address: _____

Address: _____

Insured's Name: _____

Insured's Name: _____

Policy/Group #: _____

Policy/Group #: _____

Person responsible for account: _____ Phone #: _____

Billing address (if different from above): _____

Date you last saw a dentist: _____ Dentist Name: _____

Who may we thank for referring you? _____

I AUTHORIZED MY INSURANCE COMPANY TO PAY STOCKBRIDGE DENTAL CARE, P.C. BENEFITS THAT OTHERWISE ARE PAYABLE TO ME DIRECTLY.

- Internet
- Yellow Pages
- Walk-In
- Friend/Family
- Other

Patient (or guardian) Signature _____ Date: _____