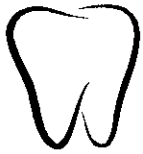

Plattsburgh Family Dentistry

Full Legal Name: _____ **Nickname**:_____
First *MI* *Last*

Male □ **Female** □ **Date of Birth:**_____**Social Security#**: _____
(required for all patients 18yrs+)

Home#:_____ **Work#**:_____ **Cell#**:_____

Address:_____

Email Address: _____

Emergency Contact Name:_____**Phone #**:_____

For Patients Under 18:

Parent/Guardian Name:_____**Phone#**: _____Social Security #_____

Address(If different from above):_____Date of Birth_____

Do you have Dental Insurance? YES NO

Dental Insurance Co._____ Group#_____ ID#/SS#_____

Subscriber Name_____Subscriber Date of Birth_____ Employer_____

Additional (Secondary) Insurance

Dental Insurance Co._____ Group#_____ ID#/SS#_____

Subscriber Name_____Subscriber Date of Birth_____Employer_____

I understand that I am responsible for all costs of dental treatment, regardless of any insurance, and/or financial situations.

Signature of Responsible Party:_____ Date_____