Dr. Stephen Clemens

-Practice limited to oral surgery-

Getting Acquainted

Date: _____

Patient Name:

First: _____ Last: _____

Home Phone#: _____ Alternate Phone#: _____

E-Mail : _____Patient Birthdate: _____

Home Address: (street) _____

(City+State) _____(Zipcode) _____

If patient is under 18yrs old:

Name of Person responsible for patient (payemnt and/or refunds) : _____

Phone #: _____ Address: _____

DENTAL INSURANCE INFO:

INS NAME: _____INS PHONE#: _____

Name of Subscriber: _____

ID/SS#: _____Subscriber's DOB: _____

Employer/Group Name: _____Group/Plan #: _____

DENTAL SECONDARY INS: (if applicable)

INS NAME: _____ INS PHONE#: _____

Name of Subscriber: _____

ID/SS#: _____Subscriber's DOB: _____

Employer/Group Name: _____ Group/Plan #: _____