Mark J. Lavin
PRACTICE LIMITED TO PERIODONTICS

TODAY'S DATE _____/_____/_____

PATIENT NAME:		
STREET ADDRESS:		
CITY:	STATE:	ZIP:
HOME PHONE:	CELL PHONE:	
DATE OF BIRTH:	SSN(REQUIRED):	
NAME OF EMPLOYER:	WORK PHONE:	
NAME OF SPOUSE/PARENT/GUARDIAN:		
CONTACT PHONE:		
WHO IS RESPONSIBLE FOR THIS ACCOUNT:		

DO YOU HAVE DENTAL INSURANCE: YES NO

POLICY HOLDER NAME:	
POLICY HOLDER DOB:	POLICY HOLDER SSN:
NAME OF INSURANCE COMPANY:	
EMPLOYER INSURANCE IS THROUGH:	

EMERGENCY CONTACT INFORMATION

NAME :
PHONE NUMBER:

WHO REFERRED YOU TO OUR OFFICE?
WHAT IS THE REASON YOU ARE SEEING US TODAY? (AS YOU UNDERSTAND IT)

PLEASE LIST ANY ADDITIONAL QUESTIONS OR AREAS OF CONCERN YOU HAVE ABOUT YOUR PERIODONTAL HEALTH :