Mark J. Lavin
PERIODONTICS & DENTAL IMPLANTS

**Today's Date:** _____

## Patient Information

**Patient Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone:** (  ) _____

**Cell Phone:** (  ) _____

**Date of Birth:** _____

**SSN (required):** _____

**Email Address:** _____

## Responsible Party (if under 18)

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Phone Number:** (  ) _____

**Date of Birth:** _____

**SSN (required):** _____

## Dental Insurance Information

**Policy Holder Name:** _____

**Policy Holder DOB:** _____

**Policy Holder ID:** _____

**Policy Holder Employer:** _____

**Dental Insurance Company:** _____

## Emergency Contact Information

**Name:** _____

**Phone Number:** (  ) _____

**Who referred you to our office? (*Correspondence will be sent to your referring dental 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:**

_____

_____