WONDER
FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370
Phone: (360) 779-1566 | Fax: (360) 779-6879

NEW PATIENT INFORMATION

PATIENT INFORMATION

Name: ________________________________ Preferred Name: ____________________ DOB: ____________

Address: ____ City: ________________ State: _____ Zip: ________

Home Phone: ________________________ Cell Phone: ________________________ SSN: __________________

Email: ____ Would you like text and/or email reminder?: ◯ Yes ◯ No

If patient is a minor, give parent's or guardian's name:

____

Please check one: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Patient's Employer: ____ Work Phone: ________________________

Employer Address: ________________________________ City: ________________ State: _____ Zip: ________

Spouse's Name: ________________________ Employer: __________________ Work Phone:

____

Are you a full-time student? __________ Are you a military veteran? __________ Are you 65 or older? ___________

Whom may we thank for referring you to our office?: ____

Emergency Contact: ____ Phone: __________________________

DENTAL INSURANCE INFORMATION

Name of Subscriber: ____ Relationship to Patient: ________________

Address: ____ City: _______________ State: ______ Zip: ________

Phone Number: __________________ DOB: ______________________ SSN: ___________________________

Employer: ____ City: _______________ State: ______ Zip: ________

Insurance Company: ________________________ Group Number: ________________ Policy ID: ______________

Insurance Company Address: _______________________________________ Phone Number: ________________

How much is your deductible?: ______________________ Maximum Annual Benefit: ________________________

-- If you have dual coverage, please complete section below --

Name of Subscriber: ____ Relationship to Patient: ________________

Address: ____ City: _______________ State: ______ Zip: ________

Phone Number: __________________ DOB: ______________________ SSN: ___________________________

Employer: ____ City: _______________ State: ______ Zip: ________

Insurance Company: ________________________ Group Number: ________________ Policy ID: ______________

Insurance Company Address: ____ Phone Number: __________________

How much is your deductible?: _________________________ Maximum Annual Benefit: ___________________________

MEDICAL INSURANCE INFORMATION

(Medical insurance might cover some of your dental procedure, we will as courtesy obtain pre-authorizations for you)

Name of Subscriber: ____ Relationship to Patient: __________________

Address: ____ City: _________________ State: ________ Zip: _________

Phone Number: _____________________ DOB: _________________________ SSN: ______________________________

Employer: ____ City: _________________ State: ________ Zip: _________

Insurance Company: ___________________________ Group Number: __________________ Policy ID: ________________

Insurance Company Address: ____ Phone Number: __________________

ACCIDENT OR INJURY INFORMATION (To be completed if the reason for today's visit is due to an accident)

Please provide details of the accident

Date and Location: ____

Details of accident or injury: ____

____

____

____

____

Have you consulted another physician regarding any injuries resulting from this accident? __________________________

Name of physician: _____________________________________Date first seen by another physician: _______________

Could this injury be covered under Worker's Compensation? _______________

Patient Signature: ____ Date: ______________________