Paul C. Kazmer, DMD, MS
Periodontics • Implants

Patient Information

Date: _____ Birth Date: _____ Social Security #:_____

Name: _____ Sex: ☐M ☐F

How do you prefer to be addressed by the doctor and staff? _____

Address: _____ City: _____ State: ____ Zip Code: _____

Home Phone: _____ Business Phone: _____Cell Phone /Pager: _____

E-mail:_____ Best method to correspond w/ you: ○ Mail ○Home # ○Work# ○Cell # ○ E-mail

Patient Employed By: _____ Occupation: _____

Business Address: _____

Spouse's Name (***or*** parents name/information if patient is minor): _____

Spouse Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Local Pharmacy:_____ Address:_____ Phone:_____

Primary General Dentist: _____ Other Dentist/ Specialist seen for routine care _____

Emergency contact/ phone number: _____

Dental Insurance – please provide your insurance card so we can make a photocopy

Subscriber Name: _____ Relation To Patient: _____ Birth Date :_____

Subscriber Employed By: _____ Occupation: _____ Social Security #:_____

Insurance Company: _____ Insurance Co Phone#:_____

ID Number_____

Secondary dental insurance coverage:

Subscriber Name: _____ Relation To Patient: _____ Birth Date :_____

Subscriber Employed By: _____ Occupation: _____ Social Security #:_____

Insurance Company: _____ Insurance Co Phone#:_____

ID Number_____