

*GREGORY L. SAWYER, D.D.S.*  
*MATTHEW A. DIERCKS, D.D.S.*

**WELCOME TO OUR PRACTICE!**

**ABOUT YOU**

Today's Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_

Last First Mi Mr Mrs Ms Dr  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Social Security #: \_\_\_\_\_  Male  Female  
 Single  Married  Divorced  Widowed  Separated

**Home Address:** \_\_\_\_\_  
Street City State Zip  
Home Phone #: (\_\_\_\_) \_\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_  
Driver License #: \_\_\_\_\_ Where & When are best times to reach you? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Other Family members seen by us: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Street/PO box City State Zip

**Neighbor or Relative Not Living With you**

His/her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip

**Person Responsible for account if other than yourself**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Street City State Zip

**SPOUSE INFORMATION**

His/Her Name: \_\_\_\_\_ Birth date: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_ Drivers License #: \_\_\_\_\_

**INSURANCE INFORMATION**

**Primary Dental Insurance**

Insurance Company Name \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group/ Policy #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Street/PO box City State Zip  
Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_  
Insured's Birth Date \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street/PO box City State Zip

**Secondary Dental Insurance**

Insurance Company Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Group/ Policy #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Street/PO box City State Zip  
Insured's Name: \_\_\_\_\_ Insured's Social Security #: \_\_\_\_\_  
Insured's Birth Date \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_ Insured's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Street/PO box City State Zip

