WELCOME TO COLORADO PERIODONTAL ASSOCIATES

Full Name: _____ Cell Phone: _____ Home Phone: _____

Address: _____ City:_____ State: ___ Zip: _____

Date of Birth: _____ Height: _____ Weight: _____ Sex: M F

Email Address: _____ Social #:_____

Primary Dental Insurance:

SS# or Member ID#:_____ Employer: _____

Dental Insurance Carrier: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Secondary Dental Insurance:

SS# or Member ID#:_____ Employer: _____

Dental Insurance Carrier: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

General Dentist Name: _____ Phone Number: _____

Physician Name: _____ Phone Number: _____

*Date of last physical examination: _____

*Are you currently under the care of a physician? Y N

If yes, please explain: _____

*Are you currently taking prescription medication, over the counter medication, herbs or supplements? Y N

Please list:

_____

_____

_____

*Please list any past/recent surgeries or hospitalizations (include dates):

_____

_____

_____

*Pharmacy (name & cross streets): _____