



# Welcome to Dr. Christine Theroux Family and Cosmetic Dentistry!

## PATIENT INFORMATION

Date \_\_\_\_\_ Home Phone  
(\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_  
Last Name First Name Middle Initial

SS/HIC/Patient ID # \_\_\_\_\_ E-mail \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Widowed  Single  Minor  
 Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/ School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## DENTAL INFORMATION

Former Dentist \_\_\_\_\_ Date of last dental care/X-rays \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Middle Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Person Responsible Employed by \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Business Address \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_

Names of other dependents covered under this plan \_\_\_\_\_