Thomas E. Wright III, D.D.S., Inc.
Practice Limited to Periodontics and Dental Implants

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ABOUT YOU

Today's Date:_____ E-mail address: _____

Name:_____ I prefer to be called: _____
Last First Middle

D.O.B: __/__/___ Age:____ Social Security #:_____ Male or Female Status: ___S ___M___D ___W

Home Address:_____
Number Street City State Zip

Home #:_____ Work #: _____ Mobile #: _____

Best phone number to confirm appointments:_____

Have you ever been a patient of our practice? Yes or No When?_____ Whom may we thank for referring you?_____

Spouse Name: _____ D. O. B:___/___/____ Social Security #: _____

Employer: _____ Occupation: _____

Employer's address: _____

If minor, Father's name: _____ Phone #: _____ Address: _____

If minor. Mother's name: _____ Phone #: _____ Address: _____

Emergency Contact Information

His/Her name: _____ Relationship:_____

Contact #: _____ Alternate contact #:_____

Insurance Information

ALL INSURANCE INFORMATION MUST BE COMPLETE IN ORDER FOR OUR OFFICE TO FILE.

Primary Insurance Dental coverage? ___Yes ___No Medical coverage? ___Yes ___No

Insurance Company Name:_____ Group # (Plan, Local, or Policy #): _____

Insurance company address:_____ Insurance phone #:_____

Insured's name:_____ Insured's Date of Birth:___/___/_____ Insured's S.S.N:_____

Patient's relationship to insured:_____

Insured's Empolyer:_____ Employer's address:_____

Secondary Insurance Dental coverage? ___Yes ___No Medical coverage? ___Yes ___No

Insurance Company Name:_____ Group # (Plan, Local, or Policy #): _____

Insurance company address:_____ Insurance phone #:_____

Insured's name:_____ Insured's Date of Birth:___/___/_____ Insured's S.S.N.: _____

Patient's relationship to insured: _____

Insured's Empolyer: _____ Employer's address: _____

For all first time appointments, payment is due in full. Today I will be paying today with __Cash ___Check ___Credit Card