FAIRLAWN FAMILY DENTISTRY

1813 SW Fairlawn Rd
Topeka, KS, 66604
(785) 272-9443

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Date:_____

PATIENT INFORMATION

First Name:_____ Middle Name: _____ Last name: _____

Preferred Name: _____Birthdate (DD/MM/YY):_____SS# _____

Address_____City_____State_____Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for_____years

Home Phone #( ) _____Cell Phone ( ) _____Work Phone ( ) _____

E-mail: _____

Employer_____Employer Phone ( ) _____

Employer Address_____City_____State_____Zip_____

Spouse or Parent's Name_____Employer_____Work Phone ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____Phone ( ) _____

RESPONSIBLE PARTY (if different from patient)

Name of Person
Responsible for this Account_____Relation to Patient _____
Social Security Number:_____

Address _____ Home Phone ( ) _____

Birthdate _____ Currently a patient in our office? ☐Yes ☐No

Employer _____ Work Phone ( ) _____

E-Mail_____Cell Phone ( ) _____

INSURANCE INFORMATION

Policy Holder: _____Relation to Patient _____

Birthdate_____Social Security #_____Employed since: _____

Employer_____Work Phone # _____

Employer Address_____City_____State_____Zip _____

Insurance Company_____Group #_____Policy # _____

ADDITIONAL INSURANCE

Name of Insured_____Relation to Patient _____

Birthdate_____Social Security #_____Employed since: _____

Employer_____Work Phone # ( ) _____

Employer Address_____City_____State_____Zip _____

Insurance Company_____Group #_____Policy # _____

We are happy to assist you in submitting your insurance forms. Please remember that no insurance company covers all dental fees and that your bill is your personal responsibility.