BRAFMAN
FAMILY DENTISTRY

KEVIN H. BRAFMAN D.D.S. WENDY W. BRAFMAN D.D.S.

Patient Information

Today's Date:_____/_____/_____
Name (last, first, mi):_____
Male Female Birthdate: _____/_____/_____ Age: ____
SS#:_____
Mailing Address:_____
_____
Home Phone #( )_____
Work Phone #( )_____
Cell Phone #( )_____
E-mail Address:_____
Referred by: _____
Employer: _____ How Long? ____
Employer's Address:_____
_____
Occupation: _____
Status: **Minor Single Married Divorced Separated Widowed**
Spouse's Name: _____
Do you have children? **Yes No** How Many? _____

Insurance Information

Primary Dental Insurance
Co. Name: _____
Address:_____
_____
Phone#:( )_____
Insured's ID#:_____
Group # (Plan, Local, or Policy#): _____
Insured's Name:_____
Relation:_____
Date of Birth: ____/____/_____
Insured's Employer: _____

Secondary Dental Insurance
Co. Name:_____
Insured's ID#:_____
Group # (Plan, Local, or Policy#):_____
Insured's Name_____
Relation: _____
Date of Birth: ___/___/____
Insured's Employer: _____

Account Information

Person ultimately responsible for account
Name:_____
Relation:_____
Billing Address:_____
_____
SS#:_____
Drivers License#: _____
Work Phone:( )_____

Payment Method: **Cash Check Credit Card**
_____ _____/_____
Enter credit card # above (if accepted)

_____ (*please initial*) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

In Event of Emergency

Emergency Contact Person_____
Relationship: _____
Home #:( )_____
Work #:( )_____
Cell Phone #:( )_____
Who is your Medical Doctor?_____
Medical Doctor's Phone#:_____

Confirmation of Appointments

How should we confirm all of your future appointments?
phone email text any of the above

To avoid receiving multiple confirmation attempts, we ask that you respond promptly.