



2335 SW 320th Street #2
Federal Way, WA 98023
tel (253) 952-6990 fax (253) 838-7009
frontdesk@mcgrifffamilydentistry.com

Welcome to our office. We appreciate the confidence you place with us to provide dental service. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any question, don't hesitate to ask.

Date _____

PATIENT'S NAME _____ Preferred Name _____

Male Female Social Security No. _____ - _____ - _____ Birthdate _____ / _____ / _____

Mailing Address _____ Home Phone (____) _____ - _____

City _____ State _____ Zip Code _____

Billing Address (if different than above) _____

City _____ State _____ Zip Code _____

Pager (____) _____ - _____ Cell (____) _____ - _____ Fax (____) _____ - _____ E-mail _____

Married Single Divorced Separated Widowed

Whom may we thank for referring you? _____

Name of Spouse _____ Birthdate _____ / _____ / _____ Social Security No. _____ - _____ - _____

Patient Occupation _____ Employer _____ Work Phone (____) _____ - _____

Spouse Occupation _____ Employer _____ Work Phone (____) _____ - _____

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group# _____	Insurance Co. _____ Group# _____
ID No. _____ - _____ - _____	ID No. _____ - _____ - _____

Person responsible for payment: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name _____ Home Ph. No. (____) _____ - _____ Work Ph. No. (____) _____ - _____

Relationship to Patient _____