Regina M. Dailey, D.M.D.
Dentistry

Patient Information

Today's date:

General Information

Name: _____ I prefer to be called: _____

❍ Male ❍ Female ❍ Minor ❍ Single ❍ Married ❍ Partnered ❍ Widowed ❍ Divorced ❍ Separated

Birthdate: ____ /____ /____ Social Security # _____ Drivers license # _____

Address: _____ City _____ State _____ Zip _____

Tel # (home) _____ Tel # (work) _____ Ext. _____

Email address _____

Other family members seen at this office: _____

Referred by whom: _____

Employer: _____ Occupation: _____

Employer's address: _____ City _____ State _____ Zip _____

Person to contact in case of emergency: _____

Relationship: _____ Tel # _____

Person Responsible for Account if Other Than Yourself

Name: _____ Relationship: _____

Birthdate: ____ /____ /____ Social Security # _____ Drivers license # _____

Tel # (home) _____ Tel # (work) _____ Ext. _____

Employer: _____

Insurance Information

Primary Dental Insurance

Insurance co. name: _____ Group # _____ Tel # _____

Insurance co. address: _____ City _____ State _____ Zip _____

Insured person: ❍ Information already provided above, in full, under "Person Responsible for Acct"

❍ Insured's name: _____

Birthdate: ____ /____ /____ Social Security # _____

Employer: _____ Tel # (work) _____ Ext. _____

Employer's address: _____ City _____ State _____ Zip _____

Secondary Dental Insurance

Insurance co. name: _____ Group # _____ Tel # _____

Insurance co. address: _____ City _____ State _____ Zip _____

Insured person: ❍ Information already provided above, in full, under "Person Responsible for Acct"

❍ Insured's name: _____

Birthdate: ____ /____ /____ Social Security # _____

Employer: _____ Tel # (work) _____ Ext. _____

Employer's address: _____ City _____ State _____ Zip _____