Brian Lyngaas, D.D.S.

Patient Info

Name: _____

E-mail Address: _____

Birthdate: __/__/__ SS #: _____

Gender: Male Female

Address: _____

City: _____ State: ____ Zip: _____

Single Married Divorced Widowed Seperated

Hm #: ( ) _____ Cell #: ( ) _____

Wk #: ( ) _____ Ext: ____

Employer: _____

Employer's Address: _____

Occupation: _____

How long there: _____

Where & when are the best times to reach you?

_____

Whom may we Thank for referring you?

_____

Other family members seen by us:

_____

Previous / Present Dentist: _____

Last Visit Date: __/__/__

Insurance

Primary

Dental Coverage: YES NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__

Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: YES NO

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ( ) _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: __/__/__

Insured's ID #: _____

Insured's Employer: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name: _____ Relation: _____ Cell #: ( ) _____ Hm #: ( ) _____

I understand that the information that I have given today is correct to to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: __/__/__