Kyle M. Triggs, D.M.D., P.C.

(Please fill out form completely)

GENERAL INFORMATION

Name ______________________________ Birthday ______-______-______ M _____ F_____

Social Security # __________-______-__________ Driver's license #______________ State _______

Physical Address ______________________________ City ________________ State _____ Zip _______

Mailing Address ______________________________ City ________________ State _____ Zip _______

Phone # HOME ________________ WORK ________________ CELL ________________

E-mail ______________________________ May we send you an email or text reminder? Yes/No

Employer ______________________________ Occupation ______________________________

Person responsible for account ______________________________

Name, Address and Phone Number of nearest relative NOT living with you ______________________________

____

Name of Spouse or Parent (if minor) ______________________________ Birthday ______-______-______

Social Security # __________-______-__________

Employer ______________________________ Occupation ______________________________

DENTAL INFORMATION

List dental concerns ______________________________

List appearance changes desired to your smile or individual teeth ______________________________

____

Referred from: Internet:___ Phone Book:___ Insurance:_____ Patient:______________ Other:______________

INSURANCE INFORMATION

PRIMARY

Employee Name ______________________________ Social Security # __________-______-__________

Relationship to patient ______________________________ Employee's Birthday ______-______-______

Employer ______________________________ Work Phone ________________

Name and address of Insurance Co. ______________________________

Group # ______________________________ Ins. ID # ______________________________

SECONDARY

Employee Name ______________________________ Social Security # __________-______-__________

Relationship to patient ______________________________ Employee's Birthday ______-______-______

Employer ______________________________ Work Phone ________________

Name and address of Insurance Co. ______________________________

Group # ______________________________ Ins. ID # ______________________________