David R. Englehart, D.M.D.
220 Regent Court, Suite D
State College, PA 16801

WELCOME TO OUR OFFICE

Patient Information:

Patient Name:_____
Street Address_____
City/State_____ zip code_____
Home Phone_____ work phone_____cell phone_____
Date of Birth_____/_____/_____ Soc. Sec. #_____

Employer_____Address_____
City/State_____zip code_____

If patient is a full-time student, name of school_____

In case of an emergency, who should be notified?_____
Phone_____ Relationship to patient_____

Who may we thank for referring you?_____

Dental Insurance Information: (Primary)

Policy Holder_____
Relationship to Patient_____Date of Birth_____/_____/_____
Address (if different than patient)_____
City/State_____zip code_____

Policy Holder employed by_____
Address_____
City/State_____zip code_____
Soc. Sec. #_____Work Phone_____

Insurance Company_____Group #_____
Insurance Company Address_____
City/State_____zip code_____
Phone_____

continued . . .

<u>Dental Insurance Information</u>: (Secondary)

Is patient covered by additional insurance? ___Yes ___No
Policy Holder_____
Reltionship to patient_____Date of Birth_____/_____/_____
Address (if different than patient)_____
City/State_____Zip Code_____

Policy Holder Employed by_____
Address _____
City/State_____Zip Code_____
Soc. Sec. #_____Work Phone_____

Insurance Company_____Group #_____
Insurance Company Address_____
City/State_____Zip Code_____
Phone_____