



Tyler Carter, DDS

Randy Weinschel, DDS

The Road to a Lifetime of Smiles

PATIENT INFORMATION

DATE: _____

Last Name _____ First Name _____ Middle I _____ Gender _____
 Prefers to be addressed by _____ Date of Birth ____/____/____ Age _____
 Address _____ Apt# _____
 City _____ State _____ Zip _____ Home Telephone _____
Emergency Contact: Name _____ Telephone* _____
 Other family members treated at this office _____

PARENTAL INFORMATION

Mother

Name _____
 Date of Birth ____/____/____
 Social Security# _____
 Cell Phone# _____
 Email _____
 Single _____ Married _____
 Widowed _____ Divorced _____
 Separated _____ Guardian _____
 Employer _____
 Address _____
 Telephone _____

Complete if DIFFERENT from Patient's home information:

Home Address _____
 City _____ State _____ Zip _____
 Home Telephone _____

Father

Name _____
 Date of Birth ____/____/____
 Social Security# _____
 Cell Phone# _____
 Email _____
 Single _____ Married _____
 Widowed _____ Divorced _____
 Separated _____ Guardian _____
 Employer _____
 Address _____
 Telephone _____

Complete if DIFFERENT from Patient's home information:

Home Address _____
 City _____ State _____ Zip _____
 Home Telephone _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Company _____
 Address _____
 City _____ State _____ Zip _____
 Insurance Telephone _____
 Policy/ Group# _____
 Policy Holder _____
 Relationship to Patient _____

Secondary Insurance

Company _____
 Address _____
 City _____ State _____ Zip _____
 Insurance Telephone _____
 Policy/ Group# _____
 Policy Holder _____
 Relationship to Patient _____

REFERRAL INFORMATION

How did you hear about our office?

