Dr. Lemke and Dr. Mehandru

ADVANCED PERIODONTICS, DENTAL IMPLANTS, LASER THERAPY

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Today's Date _____ Email:_____

Mr/Mrs/Ms/Miss _____Birthday _____SS# _____

Address _____City _____State_____Zip _____

Home Phone _____Business Phone _____Cell Phone _____

Marital Status _____Spouse's Name _____SS#_____

Spouse's Birthdate _____Spouse's Contact Phone Number _____

Person Responsible for This Account _____Relation to Patient _____

Parent's Name (If Patient is a Minor) _____

Parent's Address (If Different From Above) _____

Parent's Contact Phone Number_____

Patient or Parent's Employer _____

Employer Address _____City _____State _____Zip_____

Spouse's or Parent's Employer _____

Spouse's Employer Address _____City_____

Spouse's Employer State _____Zip_____

Referred to This Office By_____

General Dentist's Name _____

Signature of Patient _____

Parent's Signature_____
(If Patient is a Minor)

IF YOU HAVE ANY DENTAL INSURANCE AND WANT OUR OFFICE TO SUBMIT IT FOR YOU, YOU MUST BRING A COMPLETED INSURANCE FORM OR AND INSURANCE CARD TO OUR OFFICE AND FILL OUT THE BACK PAGE OF THIS FORM. OTHERWISE, WE WILL NOT BE ABLE TO FILE INSURANCE FOR YOU.