Dumont Family Dental
Dr. Christopher J. Restieri 110 West Shore Ave . Dumont NJ . 07628 201.384.9519

PATIENT INFORMATION:

Name: _____ **SSN: #**_____-____-_____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Age: _____ **Date of Birth:** _____/_____/_____

Cell Phone: _____-_____-_____ **Home Phone:** _____-_____-_____ **Business Phone:** _____-_____-_____

Email: _____@_____ **Best way to contact:** (circle one)
Cell / Home / Business / Email

Occupation: _____ **Employer:**_____

Employer Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Name of Spouse: _____ **Spouse Date of Birth:** _____/_____/_____

If patient is a student -- Name of School: _____

How did you hear about our office? _____
(our website/family and friends/Instagram/Facebook/other….?)

RESPONSIBLE PARTY

Name of person responsible for account: _____

Relation to Patient: _____

INSURANCE INFORMATION

Dental Insurance? Yes _____ No _____ **Company:** _____

PLEASE PRESENT YOUR INSURANCE CARD SO WE MAY HAVE A COPY ON FILE

Name of Insured: _____ **Date of Birth:** _____/_____/_____ **SSN: #**_____-____-_____

DENTAL HISTORY

Reason for todays visit: _____

Former Dentist/Dental Practice: _____

Practice Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Date of Last Dental Visit: _____/_____/_____ **Date of last dental X-RAYS:** _____/_____/_____

Patient Signature: _____ Date:____/____/_____