

W E D G E W O O D
E N D O D O N T I C S

Chris Ettrich DDS, MSD

Patient Information

Name _____ Male Female Title: Mr. Mrs. Ms. Dr.

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Nickname _____ Email _____ SS # _____ Date of Birth _____

Employer _____

Employer Address _____ City _____ State _____ Zip _____

Referring Dentist _____ General Dentist _____

Premedication required

~~~~~  
**Person Responsible for Account/Payment** \_\_\_\_\_ Relationship \_\_\_\_\_

**Please fill out if different from patient:**

Name \_\_\_\_\_ SS # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

~~~~~  
Dental Insurance Yes No

Primary Insurance Carrier _____ Insurance Company Phone Number _____

Address to submit claims _____ City _____ State _____ Zip _____

Name of Policyholder _____ SS # _____ Group # _____

Employer _____ Work Phone _____ Date of Birth _____

Secondary Insurance Carrier _____ Insurance Company Phone Number _____

Address to submit claims _____ City _____ State _____ Zip _____

Name of Policyholder _____ SS # _____ Group # _____

Employer _____ Work Phone _____ Date of Birth _____

All of the above information is true to the best of my knowledge.

Signature of Patient/Guardian

Date