KENNEWICK FAMILY SMILES

Dr. Isaac King, D.D.S
312 N Delaware St
Kennewick, WA 99336
(509) 735- 6341

Today's Date:

ABOUT YOU			
Name:		Male:	Female:
I prefer to be called:		Married:	Widowed:
SS#:	DL#:	Email:	
Birthday:	Single:	Divorced:	Separated:
Home Phone:		Spouse's Name:	
Address:		Their Employer:	
City:	State: Zip:	Phone:	
When was your last dental visit?			

EMPLOYER

Employer _____

Work Phone_____ Occupation: _____

Whom May We Thank for Referring You?_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (Other than your home phone number)

Name _____ Relationship _____Phone _____

Name _____ Relationship _____Phone _____

INSURANCE INFORMATION	
PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured:	Name of Insured:
Date of Birth:	Date of Birth:
Relationship to Patient:	Relationship to Patient:
Insurance Company:	Insurance Company:
Group #:	Group #:
Policy ID #:	Policy ID #:

I understand that the information that I have given today is correct to the best of my knowledge.
I also understand that this information wil be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status

Signature **Date**