



*Richard A. Gagne, DDS, Inc.*

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ NICK NAME \_\_\_\_\_

Married  Single  Child  Other

DATE OF BIRTH \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT# \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

**PLEASE LIST YOUR PHONE NUMBERS IN THE ORDER WHICH YOU WOULD LIKE TO BE CONTACTED:**

PHONE #1 \_\_\_\_\_ PHONE #2 \_\_\_\_\_  
Hm Wk Cell Hm Wk Cell

EMPLOYER \_\_\_\_\_ CITY \_\_\_\_\_ PHONE \_\_\_\_\_

E-MAIL \_\_\_\_\_

HOW DID YOU HEAR ABOUT OUR OFFICE? \_\_\_\_\_

**EMERGENCY CONTACTS**

NAME \_\_\_\_\_ RELATION \_\_\_\_\_ PH # \_\_\_\_\_ # \_\_\_\_\_

NAME \_\_\_\_\_ RELATION \_\_\_\_\_ PH # \_\_\_\_\_ # \_\_\_\_\_

**PRIMARY DENTAL INSURANCE POLICY**

POLICY HOLDER \_\_\_\_\_ ID# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ CITY \_\_\_\_\_ PHONE # \_\_\_\_\_

**SECONDARY DENTAL INSURANCE POLICY**

POLICY HOLDER \_\_\_\_\_ ID# \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ PHONE # \_\_\_\_\_ GROUP # \_\_\_\_\_

INSURANCE ADDRESS \_\_\_\_\_

EMPLOYER NAME \_\_\_\_\_ CITY \_\_\_\_\_ PHONE# \_\_\_\_\_