*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# _____