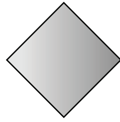

Richard A. Gagne, DDS, Inc.

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# ____________________