Dental Care
OF BOCA RATON

David Kagan, DMD

Personalized and Comfortable

Thank you for selecting our office! We are committed to providing you with meticulous, state-of-the-art dental care. We hate filling out forms as much as you do, but this information is important in helping us meet your dental needs. Thank you for your cooperation.

About You

Name: ______________________________
Last First M.I. Mr. Mrs. Ms. Dr.

Preferred Name: ______________________________

Birthdate: ___/___/___ S.S.: ______________________________

Home Address: ______________________________

____
City State Zip

❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Home: ______________ Pager/Cell: ______________

Work: ______________ Ext #: ______________

E-mail Address: ______________________________

What is the best method to reach you? ______________________________

____

Employer: ______________ Occupation: ______________

Present Dentist: ______________ How Long?: ______________

Last Visit Date: ______________________________

Has any member of your family ever been treated in our office?

❒ Yes ❒ No

Whom may we thank for referring you? ______________________________

____

Responsible Party Information or Policy Holder Information

Name: ______________________________
Last First M.I. Mr. Mrs. Ms. Dr.

Relationship to Patient: ______________________________

Birthdate: ___/___/___ S.S.: ______________________________

Home Address: ______________________________

____
City State Zip

Home: ______________ Pager/Cell: ______________

Work: ______________ Ext #: ______________

Employer: ______________________________

Dental Insurance Co.: ______________ Group #: ______________

Insurance Co. Telephone: ______________________________

Emergency Contact Information

Name: ______________________________
Last First M.I. Mr. Mrs. Ms. Dr.

Relationship to Patient: ______________________________

Home: ______________ Pager/Cell: ______________

Work: ______________ Ext #: ______________

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.

A Dental Insurance Plan is a contract between you and your employer, or plan sponsor. It is designed to share in your dental care costs. It will not cover the total cost of your bill. We are not a participating provider on any plan. If insurance is to cover a portion of my treatment, I understand that I am responsible for whatever the insurance does not cover.

______________________________ ______________
Signature
(Parent or Guardian if patient is a minor)
Date