LESLIE G. PLATOCK, D.D.S.

COSMETIC AND GENERAL DENTISTRY

Welcome to our office. We appreciate the confidence you place with us to provide dental services.

PATIENT

LAST NAME FIRST MIDDLE			Email	TODAY'S DATE	☐ MALE ☐ FEMALE
BIRTH DATE	SOCIAL SECURITY #	MARITAL STATUS ☐S ☐M ☐W ☐D	HOME PHONE		
ADDRESS		CITY	STATE / ZIP	CELL	
DRIVER'S LICENSE #				STATE	
EMPLOYER NAME		WORK PHONE ( )	WORK ADDRESS		
NAME /PHONE OF EMERGENCY CONTACT				RELATIONSHIP	

SPOUSE: LAST NAME FIRST MIDDLE			DATE OF BIRTH	
HOME PHONE ☐SAME	CELL PHONE	SOCIAL SECURITY #		
HOME ADDRESS ☐SAME AS ABOVE		CITY	STATE	ZIP CODE
EMPLOYER ☐SELF ☐NONE ☐RET	Email	BUS. PHONE	OCCUPATION	

RESPONSIBLE PARTY FOR THIS ACCOUNT: ____

PRIMARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME	FIRST		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		

SECONDARY DENTAL INSURANCE ☐NONE

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS		CITY	STATE	ZIP CODE
INSURANCE CO. PHONE	SUBSCRIBER'S LAST NAME	FIRST		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER		

I authorize my insurance benefits to be paid directly to the doctor, Leslie G. Platock, DDS, LLC.

Signature:____ Date:________________

Print Name:____