



# Gustav E. Gates, DDS

Preserving and restoring oral health ..*Beautifully*

**Welcome to our office.** So we may provide you with the best possible care, please complete both sides of this form. All information is strictly confidential.

Patient's Name \_\_\_\_\_  
Last First Middle Name to be called

Address \_\_\_\_\_  
Street Apt# City State Zip

Male \_\_\_\_\_ Female \_\_\_\_\_ Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widower \_\_\_\_\_

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Text Message Y N

Email: \_\_\_\_\_ Would you like to receive notifications regarding appointments via email? Y N

Work Phone (\_\_\_\_) \_\_\_\_\_ Are calls allowed? Y N Best way to contact you \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ No. years Employed \_\_\_\_\_

If patient is a minor, please provide parent's or guardians full name \_\_\_\_\_

Person responsible for payment of dental services: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

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Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_

If responsible party is other than self or spouse, please fill in this section: Relationship to patient \_\_\_\_\_

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address. \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Are calls allowed? Y N

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Do you have dental Insurance? Yes No Insured employee's name \_\_\_\_\_

Employer Name: \_\_\_\_\_ Address: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Address: \_\_\_\_\_

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Whom can we thank for referring you? \_\_\_\_\_

Have you seen Dr. Gates before? Yes No When? \_\_\_\_\_ Has your name changed since that visit? Yes No

Is an immediate family member a patient here? Yes No Name: \_\_\_\_\_

Person to contact in case of emergency, in addition to immediate family: \_\_\_\_\_ Phone: \_\_\_\_\_