Crystal Lake Dental, P.C.
725 Main Street
Wakefield, MA 01880

(781) 245-6966

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available.

Date _____

PATIENT INFORMATION

Name _____ **Birthdate** _____ **SS#** _____
(First Name) (Middle Initial) (Last Name)

Address _____ City _____ State _____ Zip _____

Sex ☐M ☐F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone #( ) _____ Cell Phone ( ) _____ Work Phone ( ) _____

E-mail Address: _____

Employer _____ Employer Phone ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Daytime Phone # ( ) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone ( ) _____

RESPONSIBLE PARTY (If someone other than the patient)

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Are you currently a patient in our office? ☐Yes ☐No

Birthdate _____ Home Phone( ) _____

Employer _____ Work Phone ( ) _____

E-Mail _____ Cell Phone ( ) _____

DENTAL INSURANCE INFORMATION

Insurance Carrier _____

Group # _____ **Subscriber ID** _____

Subscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Max. Annual Benefit _____ How much is your deductible? _____ How much have you used? _____

SECONDARY INSURANCE - if applicable

Name of Sunscriber _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # ( ) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ **Group #** _____ **Subscriber ID** _____

Address _____ City _____ State _____ Zip _____

Max. Annual Benefit _____ How much is your deductible? _____ How much have you used? _____

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