BURLINGAME DENTAL ARTS
7471 SW Barbur Blvd
Portland, OR 97219
(503) 246-8447

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we will be glad to help you. We look forward to working with you in maintaining your dental health.

Who may we thank for referring you? ______________________________

FIRST NAME: ______________________ PREFERRED NAME: ______________________

MIDDLE INITIAL: ______________________ LAST NAME: ______________________

SEX: MALE FEMALE MARITAL STATUS: MARRIED SINGLE

ADDRESS: ____

____

HOME PHONE: ______________________ WORK PHONE: ______________________

CELL PHONE: ______________________ EMAIL: ______________________

PREFERRED CONTACT PHONE NUMBER: ______________________________

BIRTHDATE: ______________________ SS#: ______________________

EMPLOYER: ______________________ OCCUPATION: ______________________

EMERGENCY CONTACT: ______________________ RELATIONSHIP: ______________________

PHONE NUMBER OF EMERGENCY CONTACT: ______________________________

RESPONSIBLE PARTY / POLICYHOLDER INFORMATION

PLEASE CHECK THE BOX IF THE INFORMATION IS THE SAME AS ABOVE

NAME OF INSURED: ______________________ RELATIONSHIP: ______________________

ADDRESS: ____

____

PHONE NUMBER: ____

BIRTDATE: ______________________ SS#: ______________________

INSURANCE INFORMATION

EMPLOYER: ______________________ OCCUPATION: ______________________

INSURANCE COMPANY: ____

INSURANCE ADDRESS: ____

____

INSURANCE PHONE NUMBER: ____

ID OR SS#: ______________________ GROUP #: ______________________

SECONDARY INSURANCE INFORMATION

PLEASE CHECK THE BOX IF YOU DO NOT HAVE SECONDARY INSURANCE

NAME OF INSURED: ______________________ RELATION TO PATIENT: ______________________

ADDRESS: ____

____

HOME PHONE: ______________ WORK PHONE: ______________ CELL PHONE: ______________

BIRTHDATE: ____

ID # OR SS# OF POLICY HOLDER: ______________________________

GROUP #: ____