Dr. David V. Platt DDS
plattdental@hotmail.com
(928) 532-5200

Patient Information

First Name: _____ Last Name: _____

Birth Date: _____/_____/_____ SS#: _____-_____-_____ Drivers License: _____

Mailing Address:_____ City: _____ State: _____ Zip: _____

Main Phone: _____ Alternate Phone: _____

E-mail: _____ **Sex:** ☐ Male ☐ Female **Marital Status:** ☐ Married ☐ Single ☐ Other

Preferred Pharmacy:

Name: _____ Phone: _____ Location (City): _____

Responsible Party: (if different than patient) **Relationship to Patient:** ☐ Spouse ☐ Parent ☐ Other _____

First Name: _____ Last Name: _____

Birth Date: _____/_____/_____ SS#: _____-_____-_____ Drivers License: _____

In Case of Emergency: Relationship: ☐ Spouse ☐ Parent ☐ Other _____

Contact Name: _____ Phone: _____

Secondary Contact: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

FLIP OVER

Previous Dental Provider Information:

Dental Practice Name: _____ Doctor's Name: _____

Insurance Used With Previous Dentist: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Fax #: _____ Last Appointment: _____/_____/_____

Dental Insurance Information:

Insurance Company Name: _____ Ins. Phone Number: _____

Ins. Company Address: _____

City, State, Zip: _____

Employer: _____ Group #: _____ Payer ID: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____/_____/_____

Policy Holder Soc. Sec. # or Member ID: _____

Secondary Dental Insurance Information:

Insurance Company Name: _____ Ins. Phone Number: _____

Ins. Company Address: _____

City, State, Zip: _____

Employer: _____ Group #: _____

Policy Holder Name: _____ Policy Holder Birth Date: _____/_____/_____

Policy Holder SS # or Member ID: _____

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