Crow River Dental
Big Smiles!

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart Number:

Patient Name:

First	Last	MI	Preferred Name

Title:

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Other _____

Gender:

☐ Male ☐ Female

Family Status:

☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date:

____ /____ /_____

SS Number:

____ - ____ - _____

Previous Visit:

____ /____ /_____

Email Address:

_____@_____

Phone:	Best time to call:
Home (_____) _____ - _____	__ : ____
Mobile (_____) _____ - _____	__ : ____
Work (_____) _____ - _____ ext. _____	__ : ____

Address:_____

City:_____State:_____Zip Code:_____

If under 18 years of age, list parent(s), guardian or other adult and their phone number that could give permission for treatment.

Name:_____Phone: (____) ____ - _____

Person to contact and phone number in case of emergency.

Name:_____Phone: (____) ____ - _____

Please check the box of the Number 1 reason what would KEEP YOU FROM having dental treatment done.

☐ Fear of Pain ☐ Lack of Concern ☐ Cost of Treatment ☐ Missing Work

Please provide our office with your current insurance card if you would like us to Assist you in filing your insurance claim.