

Patient Information

Dr. Stephen D. Poss, DDS, AASM, AASDM

Patient Name Last _____ First _____ M _____ Preferred _____

Address _____

City _____ State _____ Zip _____

Home # _____ Mobile _____ Work _____

Place of Employment _____

Family Status: **Married** **Single** **Child**

Birth Date _____ SS #. _____

Email Address _____

Which way would you prefer to be reminded of your next appointment? **Text** **E-mail** **Phone**

Name of person, office or other source referring you to our office:

Spouse or responsible Person Information:

Self/Spouse/Other. Name: _____

Dental Insurance Information:

Insured's name _____ Birthdate _____

SS #. _____

Place of Employment of insured _____

Please allow us to make a copy of your Dental card

Medical Insurance Information: (Sleep patient's only)

Insured's Name _____ Birthdate _____

SS #. _____

Place of Employment of insured _____

Please allow us to make a copy of your Dental card

Signature: _____ Date: _____