Dennis L. Yossi D.D.S ❖ Kevin G. Witt D.D.S
Caring Dentistry for Adults and Children

Your cooperation in completing this questionnaire is essential to providing you with the highest standard of dental care. All information is strictly confidential and will remain with this office. Our office manager is available to assist you with the completion of this form. Please print.

Welcome to Our Dental Office

Registration Information

Date:

Name: ______________ (Last) ______________ (First) ______ (Initial) ❑ Dr. ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss

Address: ______________ (Street) ______ (Apt #) ______ (City) ______ - ______ (Zip + 4 Postal Code)

Reason for today's visit? ❑ Examination ❑ Emergency ❑ Other ______________

Is there a dental problem you would like treated immediately? ❑ Yes ❑ No Explain: ______________

Last Dental Visit: __/__ / __ Name of Dentist: ______________ Phone No.: ______________

Home Phone ( )_____ - ______ Social Sec. No. ______________ Preferred Appt. Time: _____ am/pm

Bus. Phone ( ) _____ - ______ Ext. Employer: May we call you at work?

Cell Phone ( ) _____ - ______ Email: ______________

Personal Information

Prefers to be called: ______________ Occupation: ______________

Date of Birth: ___/___/____ Age:___ Sex: ___ Marital Status: ________ Name of Spouse: ______________

Are other family members' patients at our office? ______________

Whom may we thank for referring you? ______________

Medical Priority

Family Physician: ______________ Phone: ( ) ______________

Medical Specialist (if presently under care): ______________ Phone: ( ) ______________

In case of emergency please contact: ______________ Phone: ( ) ______________

Financial Information

Person responsible for account: ❑ Self ❑ Spouse ❑ Other **Please complete all info. if different from above.**

Name: ______________ Phone: ( ) ______________

Address: ______________ (Street) ______ (Apt #) ______ (City) ______ - ______ (Zip + 4 Postal Code)

Employed by: ______________ Phone: ( ) ______________

Social Security No.: ______________

Insurance Information

Primary Dental Insurance		Secondary Dental Insurance	
Name of Subscriber	Date of Birth	Name of Subscriber	Date of Birth
Employer	Month Dental Max Renews:	Employer	Month Dental Max Renews:
Insurance Company	Phone No.	Insurance Company	Phone No.
Group No.	Yearly Max:	Group No.	Yearly Max:
ID/SSN:		ID/SSN:	
% Coverage -- Prev: Basic: Major:		% Coverage -- Prev: Basic: Major:	

Method Of Payment

❑ Cash ❑ Check ❑ MasterCard/VISA/Discover ❑ Financing (Interest - free 6 month loans)

Please inquire at the front desk about other financial options.