19853 State Route 2 Suite A3
Monroe, WA 98272

Phone 360-794-9055
kylegilldentistry@yahoo.com

Thank you for choosing our office. In order to serve you properly, please answer all questions on BOTH sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential.

PATIENT'S NAME____PREFERRED NAME___________________________

☐ Male ☐ Female   Social Security No.____________-____________-____________Birthdate______/______/ ____

Mailing Address____Email ____

City___________________________State_____Zip Code______________Home Phone No. (______) _______________

Cell Phone No. (______)_______________ How should we contact you? ☐ Home ☐ Cell ☐ Work ☐ Email ☐ Text

Patient Occupation____________________Employer_______________________Work Phone (______)_______________

Name of Spouse______________________ Birthdate______/______/_______ SSN_____________________________

Spouse Occupation____________________Employer_______________________Work Phone (______) _______________

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Other than someone living with you)

Name___________________________Home Ph. No. (______)_______________Work Ph. No. (______)_______________

Relationship to patient ____

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____

Is there anyone you would like to give us permission to speak to about your dental care? ______________________________

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover. ____________
Initials

I have been given and understand the Kyle Gill Dentistry For Your Family HIPPA Notices of Privacy Act.

Signature ____ Date ________________

Primary Dental Insurance

Employee ____

Relationship to Patient ______________________________

Employer ____

Insurance Co. _____________________Group#_________

Insurance Phone No. _______________________________

Insurance Member ID # _____________________________

Subscriber D.O.B. _________________________________

Secondary Dental Insurance

Employee ____

Relationship to Patient ______________________________

Employer ____

Insurance Co. _____________________Group#_________

Insurance Phone No. _______________________________

Insurance Member ID # _____________________________

Subscriber D.O.B. _________________________________