JASON R GORDON DDS, PC
724 PELHAM PARKWAY SOUTH
BRONX, NY 10462
347-281-9444

WELCOME

Thank you for selecting our dental office. To help us meet all of your health care needs, please complete this form as accurately as possible. Thank you.

1) PATIENT INFORMATION

This appointment is for ☐ Yourself ☐ Your Child

Patient Full Name ______________________ Social Security # ______________

Birth Date ______________ Age ________ ☐ Male ☐ Female ______________

Address ______________ # ________ City ________ State ____ Zip ______________

Full Time Student ______________ ☐ Yes ☐ No School Name ______________

Employer ______________ Occupation ______________

Previous Dentist ______________ Previous Dentist Phone ______________

Current Physician ______________ Current Physician Phone ______________

Whom may we thank for referring you ______________________________

2) TELEPHONE & EMAIL

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Email ______________ ______________

In the event of an emergency, who should we contact?

Name ______________ Relationship ______________

Home Phone ______________ Work Phone ______________

3) RESPONSIBLE PARTY

Who is responsible for this patient

Full Name ______________________ Social Security # ______________

Are you ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Date ______________ Age ________ ☐ Male ☐ Female ______________

Address ______________ City ________ State ____ Zip ______________

Employer ______________ Occupation ______________

Home Phone ______________ Work Phone ______________

4) INSURANCE INFORMATION

Dental Coverage ☐ Yes ☐ No

Insured's Name ______________ Relation ______________

Insured's Social Security # ______________ Birth Date ______________

Insured's Employer ______________________________

Insurance Group # ______________ Insurance Policy # ______________

Insurance Co. Name ______________ Insurance Co Phone ______________

Please continue on next page.