Patient

GITA SAFAIAN, DMD, MDS

New Existing Existing New Tooth Date _____

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____

Home Phone _____ Cell Phone _____

E-mail Address _____

Employer _____ Policy Holder _____

Group# _____ ID# _____

Social Security No. (if used for Insurance ID) _____

Tooth# _____ Referring Dr. _____

X-Ray To Bring To Mail No

Having discomfort? Y N

Root canal done previously? Y N

Premedication? Y N

Consultation first? Y N

Start Treatment? Y N

Insurance: Delta Anthem BCBS Cigna PPO Pequot Plus

Other None

Any other special consideration?

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