Welcome to Dr. Anthony Sidor's Office

Thank you for selecting our dental healthcare team. In order for us to provide you with the best possible dental care, please fill out this form completely. If you have any questions or need assistance please ask us – we will be happy to help.

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: _____

Patients: ☐ Policy Holder ☐ Responsible Party

Preferred Name: _____

Whom may we thank for referring you? _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder

Patient Information

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Martial Status: ◯ Married ◯ Single ◯ Divored ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ◯ I would like to receive correspondences via e-mail

Section 2

Employment Status ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Section 3

Emerg Contact Name: _____

Emerg Contact #: _____

Pharmacy Name: _____

Pharmacy #: _____

Referring physician: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Group Number: _____

Insured Soc. Sec: _____ Insured Birth Date: _____

Insured Member ID#: _____

Employer: _____ Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Please understand that we will work with your primary insurance to the best of our abilities. We cannot file your secondary insurance for you, but we will be happy to give you a receipt for all services rendered.