Wheaton
cosmetic dentistry
SumeetBeri, DDS, FIDIA, MIDIA, DIDIA

Patient Name: _____ DOB: _____ Gender_____

Home Address_____
Street City State Zip Code

Social Security #_____ Marital Status_____ Email:_____

Home #:_____Mobile#:_____Work#:_____Ext:_____

Emergency Contact: _____ Phone: _____

EMPLOYMENT INFORMATION

Employer's Name_____ Occupation_____
Employer's Address_____
Street City State Zip Code

DENTALINSURANCE INFORMATION

PATIENTS Relationship to INSURED: Self Spouse Child Other

Name of Policy Holder_____ **DOB:** _____

Insurance Company: _____ **ID#**_____**Group#**_____
Policy Holder's telephone #: _____ Policy Holder's Employer: _____
Policy Holders Address_____
Street City State Zip Code

Do you have a SECONDARY DENTAL Insurance Policy? YES NO

MEDICAL INSURANCE INFORMATION

PATIENTS Relationship to INSURED: Self Spouse Child Other

Name of Policy Holder_____ **DOB:** _____

Insurance Company: _____ **ID#** _____ **Group#** _____
Policy Holder's telephone #: _____ Policy Holder's Employer: _____
Policy Holders Address_____
Street City State Zip Code

Do you have a SECONDARY DENTAL Insurance Policy? YES NO

Patient Signature:_____**Date:** _____