Michael Imberman, D.M.D., M.Sc.D.
A Professional Corporation

PERIODONTICS • DENTAL IMPLANTS

GENERAL INFORMATION
THE FOLLOWING INFORMATION IS CONFIDENTIAL AND FOR OUR RECORDS ONLY.

Date _____

Patient's Name _____

Sex_____ Weight_____ Height_____ Birthdate_____ Age_____

Marital Status _____ Spouse's Name _____ Birthdate _____

Soc. Sec. # _____ Spouse's Soc. # _____

Residence Address _____
STREET CITY STATE ZIP

How Long have you lived there? _____

E-Mail Address _____

Home Telephone # _____

Cell Phone # _____

Employed by _____

Position _____ Years with firm _____

Business Address _____

Business Telephone # _____

Spouse Employed by _____

Business Address _____

Name of Dentist _____

How long have you been under his/her care? _____

Name and address of Physician (Medical Doctor) _____

_____

Physician's (Medical Doctor) Telephone _____

Who may we thank for referring you to this office? _____

Why were you referred to a periodontist? _____

Are you covered by Dental Insurance? _____

Name and Address of Carrier _____

_____ Policy Number _____

Person Responsible for This Account _____

Person to Notify in Case of Emergency _____

_____