Mariam Makram-Rofail, DDS

Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Date ____________

Confidential Patient Information

Name____ Marital Status_______________

Mailing Address____

Home Phone______________ Cell Phone________________ Work Phone_______________

Email Address____________________________

How may we reach you to confirm appointments and leave messages?________________________________

Social Security number_______________________ Birthdate _____________ Relationship to patient ______________

Employer ___________________ Occupation ________________________No. years employed ______________

Spouse's name __________________________________ Relationship to patient _________________________

Employer ___________________________ Occupation ____

Social Security Number ______________________ Birthdate _____________ Work phone ____________________

With whom do you authorize us to speak with about your dental care? ________________________________

If patient is a minor, please give parent or guardian's name _____________________________________

Whom may we thank for referring you to our office? ____

Insurance Information

Policy Holder's Name _____________________________________ Social Security Number ____________________

Insurance Company ____ Group No. _____________________

Insurance Co. Address ____________________________________ Insurance Co Phone _____________________

Policy Holder's Employer ____

Do you have dual coverage? _________________

Policy Holdr's name ______________________________________ Social Security Number ___________________

Insurance Company ____ Group No. ____________________

Insurance Co. Address ____________________________________ Insurance Co Phone _____________________

Policy Holder's Employer ____