Olivia Lares, D.D.S. – Berwyn Dental Connection
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PATIENT INFORMATION
Name ____ *Date of Birth _______________
FIRST MIDDLE LAST
*Social Security # __________________
Address ____
City ___________ State _____ Zip Code _______ *E-Mail ______________________________________
Home Phone # ________________ Cell Phone # ________________ Work Phone # ________________
How would you like us to contact you? (Please circle one) CALL TEXT EMAIL
How did you hear about us? ________________ Who can we thank for your referral?_______________

* Have you had any joint replacement surgery? YES NO
*Does your physician require you to pre-medicate for dental treatment? YES NO
If YES, what medication? __________________________________

Emergency Contact _____________________________ Phone #___________________
Relation ___________
Pharmacy Preference ______________________________________ Phone # ____________________

INSURANCE INFORMATION
Primary Insurance Owner: ___________________________________ SELF SPOUSE PARENT OTHER
Address (if different): ___________________________________ City, State, Zip ___________________
Date of Birth __________________ Social Security # _________________________
Employer ________________________ Member ID# ___________________ Group# ______________
Dental Insurance _____________________________ Insurance Phone #___________________________
Insurance Address____ City, State, Zip __________________

Secondary Insurance Owner: ___________________________________SELF SPOUSE PARENT
OTHER
Address (if different): ___________________________________ City, State, Zip ___________________
Date of Birth __________________ Social Security # _________________________
Employer ________________________ Member ID# ___________________ Group# ______________
Dental Insurance _____________________________ Insurance Phone #___________________________
Insurance Address____ City, State, Zip __________________

I certify that I have read and understood the above information. I acknowledge that I will not hold the dentist or any staff responsible for any errors or omission I may have made on this form.

Signature of Patient / Guardian: ________________________________
Date: _______________
Signature of Dentist ____
Date: _______________