John M Schiefelbein, DMD, PLLC
246 Division St/PO Box 787
Leavenworth, WA 98826
(509) 548-5841

Patient Name: _____ Preferred Name: _____
Last First Middle Initial

❑ Male ❑ Female ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

Social Security #: _____ Birthdate: _____ Age: _____

Home Ph: _____ Cell Ph: _____ Employer: _____ Work Ph: _____

Email: _____ ❑ may we use email for important information

Address: _____ City: _____ State: ____ Zip: _____

Mailing Address (if different) _____ City: _____ State: ____ Zip: _____

Closest Relative: _____ Relation: _____ Phone: _____

How did you hear about us? _____ ❑ Referring Office ❑ Internet ❑ Friend ❑ Family

Who is Responsible for Payment? ❑ same as above

Name: _____ Relationship to Patient: _____
Last First

Social Security #: _____ Birthdate: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Ph: _____ Cell: _____ Work: _____ Email address: _____

Primary Dental Insurance	**Secondary Dental Insurance**
Subscriber Name: _____	Subscriber Name: _____
Subscriber S.S. #: _____ Birthdate: _____	Subscriber S.S. #: _____ Birthdate: _____
Employer: _____	Employer: _____
Insurance Co: _____	Insurance Co.: _____
Group Name: _____ Group ID#: _____	Group Name: _____ Group ID#: _____
Relationship to Insured: ❑Self ❑Spouse ❑Child ❑ Other	Relationship to Insured: ❑Self ❑Spouse ❑Child ❑Other

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ Home Ph. # : _____ Other Ph. #: _____

Relationship to Patient: _____

Patient (Guardian) Signature: _____ **Date:** _____