

Welcome



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For office use only

Appointment: \_\_\_/\_\_\_/\_\_\_ at \_\_\_\_\_

Received date: \_\_\_/\_\_\_/\_\_\_

**Patient Information**

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance.

First Name:	Middle:	Last Name:	Date:
Physical Address:		City:	State: Zip:
Mailing Address:		City:	State: Zip:
<input type="checkbox"/> Home Phone:	<input type="checkbox"/> Work Phone:	<input type="checkbox"/> Cell Phone:	
Please check the preferred daytime phone			
Email Address:	Birth date:	Age:	SS#:
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
You or your parent's employer:		Occupation:	
Business Address:	City:	State:	Zip:
Person to contact in case of emergency:		Relationship:	Phone:
Name of closest relative <u>not</u> living with you:		Relationship:	Phone:
Whom may we thank for referring you to us?:			

**Responsible Party**

Name of person responsible for this account:		Phone:
Relationship to patient:	Employer:	Phone:
Business Address:	City:	State: Zip:

**Dental Benefits**

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:			Phone:
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Business Address:	City:	State:	Zip:
Deductible:	How much of annual benefit used?	Maximum annual benefit:	

**Secondary Insurance**

Name of insured:		Relationship to patient:	
Birth date:	SS#:	Date of employment:	
Name of employer:			Phone:
Business Address:	City:	State:	Zip:
Insurance Co.:	Group#:	Employer#:	
Business Address:	City:	State:	Zip:
Deductible:	How much of annual benefit used?	Maximum annual benefit:	