Susan G. Gross DDS

Smiles For Life

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ____

Date of Birth: _____

Social Security # or Drivers License #:_____

Address: _____

City, State, And Zip: _____

Home #:_____ Work #:_____ Cell #_____

Please indicate the above numbers that we can leave a message. _____

Email Address: _____

Parent/Guardian: _____ Phone #:_____

Address if Different: _____

Responsible Party if Someone other than Patient: _____

Emergency Contact: _____

If applicable, please present dental benefit/insurance card or information at time of appointment.

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

Signature:_____ Date:_____

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