

Dr. Tod Armbruster, D.D.S.

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(419)893-4141

WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you.
We look forward to working with you in maintaining your dental health.

Name _____ Date _____

PATIENT INFORMATION

Address _____ Soc. Sec. # _____
City _____ State _____ Zip _____ Phone _____ Cell _____
Sex M F Age _____ Birth Date _____ Single Married Widowed Separated Divorced
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Spouses Name (if married) _____ Email _____

BILLING AND INSURANCE INFORMATION

Person Responsible for Account _____
Relationship to Patient _____ Birth Date _____ Social Security # _____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Person Responsible Employed By _____ Occupation _____
Business Address _____ Phone _____
Insurance Company _____ Group # _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No

Subscriber Name _____
Relationship to Patient _____ Birth Date _____ Social Security # _____
Address (if different from patient) _____ Phone _____
City _____ State _____ Zip _____
Subscriber Employed By _____ Business Phone _____
Insurance Company _____ Group # _____

PERSONAL

Whom may we thank for referring you? _____
Nearest relative not living with you? _____ Phone _____

(OVER)