

Patient Information for William E. Lenkaitis D.D.S.

(Confidential Information for our files)

Name _____ Age _____
Address _____ State _____ Zip _____
Previous Address (if within 2 yrs) _____
Social Security Number _____ Birth Date _____
Residence Phone _____ Work Phone _____
* Best Phone Number For Appointment Confirmation _____
Person Financially Responsible _____ Relationship _____
Patient Employed by _____ Occupation _____
Parent/Guardian Employed by _____ Occupation _____
Spouse's Name _____ Work Phone _____
Spouse Employed by _____ Occupation _____
* Referred by _____ No. of Dependents _____
Insurance Carrier _____ Subscriber _____
Secondary Carrier, if any _____ Subscriber _____
If a full-time college student, school name _____

Everything stated in this form is correct. You are authorized to check my credit and employment history for my credit experience.

Signature of patient (or parent if minor) _____ Date _____