Dr. Robert Detrich
General, Cosmetic & Implant Dentistry
1920 Medical Avenue, Suite J
Harrisonburg, VA 22801

Are you looking for comprehensive dental care?

Yes **No**, I only want the doctor to look at this current problem.

Confidential Patient Information

Date: **Social Security Number:**

First Name: **M.I.:** **Last Name:**

Date of Birth: **Age:** **Sex:** Male Female

Marital Status: Single Married Separated Divorced Widowed Child

Mailing Address: **Email:**

City: **State:** **Zip:**

Employer: **Cell Phone:**

Occupation: **Phone:**

I prefer to be contacted to confirm appointments by: email cell home work

Are any of your family members patients here? Yes (__________________) No

How did you hear about us? Newspaper TV Internet Yellow Pages
Friend/Family (___________________) Other (_______________)

Have you seen our commercial? Yes No

Person Responsible For This Account

Who is responsible for this account? Self Spouse Parent/Guardian Other

If different than self (to be verified by phone)

Name: **Social Security Number:**

Credit Card Type: Visa MasterCard **Card Number:** **Exp:**

Date of Birth: **Phone** (work)**:**

Address (if different than above)**:** **Phone** (home)**:**

Primary Dental Insurance Information

Do you currently have dental insurance? Yes No

Insurance Company: **Employer:**

Subscriber's Name:

Date of Birth of Subscriber: **Effective Date:**

Subscriber's Social Security Number: **Group Number:**

Subscriber's ID Number:

Patient's ID Number: