Justin R. Kohlhorst, D.D.S.
Practice Limited to Periodontics

Date:_____

Please print the following completely. Your answers are considered confidential.

PATIENT INFORMATION

Circle One: Mr. Mrs. Miss. Ms. Other_____

Name: _____

I preferred to be called (name):_____

Mailing Address: _____

Physical Address:_____

City:_____

State:_____ Zip:_____

Home Phone: _____

Work Phone: _____

Cell Phone:_____

Place of Employment: _____

Soc. Sec. ID Number:_____

Sex: ( ) M ( ) F Birth Date:____/____/____

Spouse Name:_____

RESPONSIBLE PARTY INFORMATION
(If different than Patient)

Circle One: Mr. Mrs. Miss Ms. Other:_____

Name: _____

Relationship to Patient:_____

Mailing Address:_____

Physical Address:_____

City:_____

State:_____ Zip:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Place of Employment:_____

Soc. Sec. ID Number:_____

Sex ( ) M ( ) F Birth Date: ____/____/____

Spouse Name:_____

INSURANCE INFORMATION

Do you have dental insurance? ( ) Yes ( ) No Insurance Company:_____

Do you have medical insurance? ( ) Yes ( ) No Insurance Company:_____