ALCAN FAMILY DENTAL
2819 DAWSON STREET
ANCHORAGE, AK 99503

Please answer all questions on **both** sides, so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

PATIENT'S NAME ______________________ Preferred Name ______________

❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed

❑ Male ❑ Female Social Security No. _____-_____-_____ Birthdate ____/____/____

Mailing Address ______________________ Home Phone (___) ____-______

City ______________ State ______________ Zip Code ______________

Cell (___) ____-______ Fax (___) ____-______ Email ______________

Whom may we thank for referring you? ______________________

Name of Spouse ______________ Birthdate ____/____/____ Social Security No. _____-_____-_____

Patient Occupation ______________ Employer ______________ Work Phone (___) ____-______

Spouse Occupation ______________ Employer ______________ Work Phone (___) ____-______

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Employee ______________	Employee ______________
Employer ______________	Employer ______________
Insurance Co. ______________ Group# ______	Insurance Co. ______________ Group# ______
Employee's S.S. No. _____-_____-_____	Employee's S.S. No. _____-_____-_____

Person responsible for payment: ______________________

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IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name ______________ Home Ph. No. (___) ____-______ Work Ph. No. (___) ____-______

Relationship to Patient ______________________