Richard C. Ross, D.D.S.
244 State Route 308
Rhinebeck, NY 12572
(845)876-2511

DATE_____

PATIENT LAST NAME: _____FIRST NAME: _____

PARENT/GUARDIAN (required for all patients under the age of 18)

LAST NAME: _____FIRST NAME: _____

HOME ADDRESS: _____

MAILING ADDRESS:_____

HOMEPHONE: _____ WORKPHONE: _____ CELLPHONE: _____

BEST NUMBER TO CONFIRM APPT: _____SS#:_____

DRIVERS LICENSE #: _____ EMAIL ADDRESS: _____

MARITAL STATUS: _____ SEX: M F DATE OF BIRTH: _____

SPOUSE: _____

EMPLOYER NAME: _____ REFERRED BY: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____
RELATION TO PATIENT: _____ SS#: _____ DATE OF BIRTH: _____
EMPLOYER NAME AND ADDRESS: _____
INSURANCE COMPANY NAME AND ADDRESS: _____
GROUP#: _____

SECONDARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____
RELATION TO PATIENT: _____ SS#: _____ DATE OF BIRTH: _____
EMPLOYER NAME AND ADDRESS: _____
INSURANCE COMPANY NAME AND ADDRESS: _____
GROUP#: _____