Valerie M. Preston, D.D.S
8320 Falls of Neuse Rd
Raleigh, NC 27615
919-518-0540
919-518-2448 Fax

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

PATIENT

PATIENT LAST NAME FIRST MIDDLE			PREFERRED NAME TO BE CALLED	TODAY'S DATE	☐ MALE ☐ FEMALE
BIRTH DATE M. D YR	SOCIAL SECURITY NUMBER	HOME PHONE ☐ NONE MESSAGE PHONE		MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	
MAILING ADDRESS	CELL PHONE	CITY	STATE	ZIP CODE	
HOME ADDRESS ☐SAME APT. OR SPACE NO.		CITY	STATE	ZIP CODE	
NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU	RELATIONSHIP	PHONE ( )	ADDRESS		
WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?				RELATIONSHIP	

RESPONSIBLE PERSON (FINANCIAL)

PERSON RESPONSIBLE LAST NAME FIRST MIDDLE			RELATIONSHIP	
HOME PHONE ☐SAME	SOCIAL SECURITY NUMBER	DRIVER'S LICENSE NUMBER	STATE	
HOME ADDRESS ☐SAME AS ABOVE	CITY	STATE	ZIP CODE	
EMPLOYER ☐SELF ☐NONE ☐RET	BUSINESS ADDRESS	BUS. PHONE	OCCUPATION	

IF PATIENT IS UNDER AGE 21

FULL TIME STUDENT ☐YES ☐NO	SCHOOL ATTENDING	CITY	GRADE
BOTH PARENTS NAMES	MARITAL STATUS ☐S ☐M ☐W ☐D ☐SEP	IF PARENTS ARE DIVORCED, WHO HAS: LEGAL CUSTODY? ☐Mo ☐Fa FINANCIAL CUSTODY? ☐Mo ☐Fa	

PRIMARY DENTAL INSURANCE (If None or PA, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	

SECONDARY DENTAL INSURANCE ☐NONE (If, Turn Page Over)

INSURANCE COMPANY NAME	INSURANCE COMPANY ADDRESS	CITY	STATE	ZIP CODE
INSURANCE CO. PHONE NO.	SUBSCRIBER'S LAST NAME FIRST MIDDLE		SUBSCRIBER'S BIRTH DATE	
POLICY OR SOC. SEC. NO.	GROUP NO.	GROUP NAME	RELATIONSHIP OF PATIENT TO SUBSCRIBER ☐SELF ☐SPOUSE ☐CHILD ☐OTHER	