York Dental Health Associates

Bruce M Fried D.D.S. & Timothy B Wright D.D.S.

Today's date:_______________ Patient's name:______________________________

Date of birth:_______________ Social Security#:______________________________

Street address:____

City:___________________________________State:____________Zip:__________

Home Phone#:__________________________Cell Phone#:___________________________

Can we email or text you if telephone contact cannot be established?____________________

Email address:____

Marital status: (circle one) Single, Married, Separated, Divorced ,or Widowed

Employer:____Work #___________________

Do you have dental insurance through your employer?_________________________________

If so who is the insurance carrier?____

ID#_____________________________________Group #_____________________________

Name of spouse:__________________________________Cell Phone#_________________

Spouse's date of birth:___________________Spouse's social security #__________________

Spouse's employer:___________________________________Work#:____________________

Do you have insurance through their employer?____________________________________

If so who is the carrier?_____________________(check if you have double coverage)______

ID#:_____________________________________Group#:______________________________

What can we do for you today?____

Whom may we thank for referring you to our office?_______________________________

Please list any other family members that are patients here:____________________________