



CORBET LOCKE

D.D.S.

Advanced Dentistry. Exceptional Care.

Patient Information:

Mr. Mrs. Ms. Dr. First Name _____ M.I. _____ Last Name _____ Nickname _____

Sex: Male Female Birth Date _____ Age _____ Soc Sec# _____ E-mail _____

Street _____ City _____ State _____ Zip _____

Home Tel. (_____) _____ Cell (_____) _____ Have you ever been a patient here before? Yes No

Referred by _____ Nearest relative not living with you _____ Tel. (_____) _____

Employer _____ Bus. Tel. (_____) _____ Personal Payment Type: Cash Check Credit Card

Spouse/ Guarantor/ Insurance Policy Holder:

Name _____ Relation _____ S.S. # _____ Birth Date _____

Street _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel. (_____) _____

In Case of Emergency:

Name _____ Relation _____ Tel. (_____) _____

Primary Dental Insurance:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____

Telephone (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: Male Female Birth Date _____

S.S. # _____ I.D.# _____

Secondary Dental Insurance:

Employer _____

Bus. Address _____

Bus. Tel. (_____) _____ Plan _____

Ins. Co. Name _____

Address _____

City _____ State _____ Zip _____

Telephone (_____) _____

Group # _____ Group Name _____

Insured Party _____ Relation _____

Sex: Male Female Birth Date _____

S.S.# _____ I.D.# _____