BRUCE C. WETMORE, D.D.S.

Diplomate of American Board of Oral & Maxillofacial Surgery

Practice Limited to Oral & Maxillofacial Surgery

Have you or any family member previously been a patient of Dr. Wetmore? Yes___No___
If so who? _____

PATIENT INFORMATION

Social Security #_____-_____-_____ Date of Birth_____/_____/_____ Age_____

Patient Name_____ Male / Female Single/Married

Street Address_____
City, State_____Zip_____-_____
Home Phone_____ Work/Cell Phone_____
Employer_____Occupation_____
Student? F/T____ P/T____ Name of School_____

Emergency Contact/Relationship_____ Phone Number_____
Who may we thank for referring you? _____
Name of regular Dentist_____Orthodontist_____
Primary Care Physician_____ Phone Number_____

Spouse's Name__ _____ Social Security #_____
Spouse's Employer_____ Work/Cell Phone_____

BOTH PARENTS OR LEGAL GUARDIANS ARE RESPONSIBLE FOR MINOR CHILDREN

Father's Name_____ _____Social Security #_____-_____-_____
Employer_____Work/Cell Phone_____
Mother's Name_____Social Security #_____-_____-_____
Employer_____Work/Cell Phone_____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance_____
Name of Insured Person_____Date of Birth_____/_____/_____
Policy/I.D.#_____Group#_____
Insurance Address_____
City, State & Zip_____
Name of Secondary Insurance_____
Name of Insured Person_____Date of Birth_____/_____/_____
Policy/I.D.#_____Group#_____
Address_____
City, State & Zip_____

MEDICAL INSURANCE INFORMATION

Name of Insurance Company_____
Name of Insured Person_____Date of Birth_____/_____/_____
Policy/I.D.#_____Group#_____
Address_____
City, State & Zip_____ Phone Number_____

TURN PAGE OVER TO COMPLETE MEDICAL INFORMATION