Welcome to Battlefield Dental of Fredericksburg!

5996 Plank Road, Fredericksburg, VA 22407 Phone: (540)412-6793

Patient Information:

Name: First_____ Last_____ Middle Initial: _____

Address: _____ State/Zip _____-_____

Home Phone Number: _____ Cell Phone (preferred #): _____

*** Please keep in mind we only confirm via text message and/or e-mail and we ask our patients to please confirm appointments using this convenient service.

E-mail: _____ □ I would like to receive correspondence via e-mail

Sex: □ Male □Female Marital Status: □Married □Single □Divorced □Separated □Widowed

Birth Date: _____ Age:_____ Soc Sec: _____ Driver's Lic: _____

Employment Status: □Full Time □Part Time □Retired Student Status: □Full Time □Part Time

**Referred By: _____ Previous Dentist: _____ Emergency Contact:_____

(How did you hear about our office) Emergency Contact #:_____

Name of Employer: _____

Responsible Party (if different from above):

Name: _____ Relationship to Patient: _____ DOB: _____

Address (if different from above): _____ State/Zip _____ _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____ Soc Sec #: _____ Driver's Lic: _____

Employer: _____ Address: _____

Primary Insurance Policy Holder:

Name: First _____ Last_____ Phone: _____

Address: _____ State/Zip: _____ _____

Insurance Company: _____ Employer: _____

ID# or Soc Sec: _____ Relationship to Patient: _____ Alt Phone #: _____

Secondary Insurance Information:

Name: First _____ Last_____ Phone: _____

Address: _____ State/Zip_____ _____

Insurance Company: _____ Employer: _____

ID# or Soc Sec: _____ Relationship to Patient: _____