Aristos Dentistry

Dr. Christopher J. Nielsen DMD

Personal Information

Full Name:______________________________ I prefer to be called:______________

Person Responsible for account:____

Home Address:__________________________City:______________State:________ Zip:__________

Mailing Address:__________________________ City:______________ State:________Zip:__________

SSN:______________ DOB:______________ Email:______________________________

Home Phone ______________ Cell Phone ______________ Other #'s ______________________

Where would you like to be contacted for appointment reminders?
Please circle all that apply: Home / Cell / Text / Email

I consent to receiving text messages Yes / No Cell Phone Carrier ____________________
Signature ________________________

Please circle: Married / Single / Domestic Partner / Widowed

Spouse's/Partner's Name:____

Emergency Contact NOT living with you:____________________ Ph. Number:______________

Who may we thank for your referral?____

Primary Insurance Information

Name of Insured:__________________________ Subscriber ID/ SSN: ________________ DOB:______________

Employer:__________________________________ Group #____________________

Insurance Co:____________________________ Phone #:__________________________

Ins. Address:____________________________ City:________ State:________ Zip:__________

Secondary Insurance Information (if applicable)

Name of Insured:__________________________ Subscriber ID/ SSN: ________________ DOB:______________

Employer:__________________________________ Group #____________________

Insurance Co:____________________________ Phone #:__________________________

Ins. Address:____________________________ City:________ State:________ Zip:__________