solon family DENTAL

Laura M. Walsh, DMD
Nicholas J. DePaola, DDS
33695 Bainbridge Rd., Ste. 100
Solon, OH 44139
info@solonfamilydental.com
(440)248-6823 fax (440)248-9030

# Patient Information

**First Name**: _____ **Last Name**: _____
**Preferred Name (if different)**: _____
**Birthdate**: _____ **SSN**: _____ **Marital Status**: _____
**Gender**: *Male* *Female* *Prefer not to answer*

**Cell #**: _____ **Texts ok?** *Y* *N*
**Home #**: _____
**Work #**: _____
**Email address**: _____

**Address**: _____
**City**: _____ **State**: _____ **Zip**: _____

If this is your first visit, how did you hear about our office?: _____
(If someone referred you here, please tell us their name so we can thank them.)

Emergency Contact: _____ Phone: _____ Relation: _____

Preferred Pharmacy: _____ Phone: _____

**Dental Insurance Information:**

Do you have dental insurance? Y N

*If yes, please fill out as much of the following information as possible.*
*If you have a copy of your card, you may provide that to the office staff in place of this section.*

Insurance Company: _____
Patient's relationship to cardholder: *Self* *Spouse* *Dependent*
Cardholder's name: _____ DOB: _____
Employer: _____
Member ID # (or Cardholder's SSN): _____ Group #: _____
Group Name: _____ Insurance Phone #: _____

Signature _____ Date _____