Andrew Hoover, DDS

Cosmetic, General & Implant Dentistry

Patient Information

Last Name:_____First Name:_____Preferred Name:_____

Mr. Mrs. Ms. Miss Dr. Marital Status: Single Married Divorced Widowed

Date of Birth: ____-_____-_____ Sex: M F Social Security Number:_____-_____-_____

Address:_____

E-mail:_____

Mobile Phone:_____Home Phone:_____Work Phone:_____

Occupation:_____Employer:_____

Employer's Address:_____

Emergency Contact:_____ Relationship:_____Contact's Phone:____-_____-_____

Whom may we thank for referring you?_____

Would You like to receive email and text reminders for your dental appointments?: ☐ yes ☐ no

Primary Dental Insurance

Subscriber's Name:_____Relationship to Patient:_____

Subscriber"s Identification Number:_____-_____-_____ Subscriber's Date of Birth:___-___-_____

Address (if different from patient):_____

Subscribers's Employer:_____Employer's Phone Number:_____

Employer's Address:_____

Plan Name:_____Group Number:_____

Insurance Company:_____Insurance Phone Number:_____

Insurance Address:_____

Secondary Insurance

Subscriber's Name:_____Relationship to Patient:_____

Subscriber"s Identification Number:_____-_____-_____ Subscriber's Date of Birth:___-___-_____

Address (if different from patient):_____

Subscribers's Employer:_____Employer's Phone Number:_____

Employer's Address:_____

Plan Name:_____Group Number:_____

Insurance Company:_____Insurance Phone Number:_____

Insurance Address:_____

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