

**David T. Chuljian, DDS, PS**

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Today's Date \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I. title

I prefer to be called \_\_\_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_ Age \_\_\_\_\_

SSN \_\_\_\_\_

Home Address \_\_\_\_\_

City State Zip

Email Address \_\_\_\_\_

Single ( ) Married ( )

Home Phone ( ) \_\_\_\_\_

Work Phone ( ) \_\_\_\_\_

Cell phone or pager ( ) \_\_\_\_\_

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Employer \_\_\_\_\_

Address \_\_\_\_\_

City State Zip

Occupation \_\_\_\_\_ Employment Duration \_\_\_\_\_

\*\*\*\*\*

Spouse Information if applicable:

Name \_\_\_\_\_

Employer \_\_\_\_\_

SSN \_\_\_\_\_

Birthdate \_\_\_ / \_\_\_ / \_\_\_

Other family members seen by us

\_\_\_\_\_

In an emergency, whom should we contact?

Name \_\_\_\_\_ Relation \_\_\_\_\_

Phone (W) \_\_\_\_\_ (H) \_\_\_\_\_

Whom may we thank for referring you?

\_\_\_\_\_

Primary Dental Insurance

Insurance. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Group # or Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation \_\_\_\_\_ Birthdate \_\_\_ / \_\_\_ / \_\_\_

Insured's SSN \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City State Zip

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Secondary Insurance

Insurance. Co. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Group # or Policy # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Relation \_\_\_\_\_ Birthdate \_\_\_ / \_\_\_ / \_\_\_

Insured's SSN \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

City State Zip

\*\*\*\*\*

Person Responsible for Account

Name \_\_\_\_\_

Home Address \_\_\_\_\_

City State Zip

Employer \_\_\_\_\_ Driver's Lic # \_\_\_\_\_

Phone (W) \_\_\_\_\_ (H) \_\_\_\_\_

Relation \_\_\_\_\_ SSN \_\_\_\_\_

Billing Address \_\_\_\_\_

City State Zip

I affirm that the information given is correct to the best of my knowledge. I understand also that I am responsible for all costs of dental treatment, not my dental insurance company. Any unpaid balance 90 days after treatment is due and payable regardless of insurance claim status.

Signature

Date