Michael P. Teluk, DDS, PC • Scott V. Powers, DDS

2105 W. Genesee St. • Syracuse, NY 13219

(315) 468-5076

Patient Name: _____

Address: _____

City: _____ Zip: _____

Soc. Sec. #: _____

Drivers License #: _____

Birth Date: _____

Phone: _____

Home: _____

Work: _____

Cell: _____

Patient Employer: _____

Occupation: _____

Address: _____

City: _____

Patient Dental Insurance: _____

Company: _____ Plan or Group #: _____

Insurance Carrier's Name: _____

Insurance Carrier's Employer: _____

Insurance Carrier's Soc. Sec. #: _____

Insurance Carrier's Work #: _____

Insurance Carrier's Birth Date: _____

Spouse Dental Insurance: _____

Company: _____ Plan or Group #: _____

Insurance Carrier's Name: _____

Insurance Carrier's Employer: _____

Insurance Carrier's Soc. Sec. #: _____

Insurance Carrier's Work #: _____

Insurance Carrier's Birth Date: _____

Emergency Information

In case of emergency, please contact:

Name: _____

Phone (Home, Work, Cell) _____

Please let us know of other information pertaining to yourself that will assist us in better meeting your dental needs:

_____

_____

_____

I certify the above information to be true. I understand that I am responsible for all fees for services rendered to me or dependent child and that a service charge of 1.0% per month be added to accounts after 30 days. All payments agreements will be charged a $5.00 late charge.

Signature (parent if child): _____

Date: _____