

GRAND BLANC • CLARKSTON

# PERIODONTAL SPECIALISTS

*World-class care and caring*

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Please circle your preferences for contacting you when confirming appointments: Home Work Cell Email

E-Mail Address (office use only): \_\_\_\_\_

Employer: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Who do we contact in case of an emergency? \_\_\_\_\_ Phone: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Has another family member been a patient here? \_\_\_\_\_ If yes, who? \_\_\_\_\_

***I understand and agree that I am responsible for full payment of my account,  
including any amounts above and beyond my dental benefit (insurance) coverage:***

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

**If you have current dental insurance, please continue form:**

Name of Insured Employee: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured SS# \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Dental Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

**Do you have dental insurance coverage from another dental insurance company? If so, please continue form:**

Name of Insured Employee: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured SS# \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Employer: \_\_\_\_\_

Dental Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_