INNERBLOOM
DENTAL STUDIO
DR. SARAH ENRIGHT

Patient Name: _____ Preferred Name: _____

Your Address: _____

Cell Phone: (_____) _____ ▫ TEXT

Email: _____

DOB: _____ / _____ / _____ Sex: ▫ F ▫ M

How did you hear about us? _____

Approximately when was your last dental visit? _____

Previous Office/Dentist info: _____

Would you like us to contact this office for your records? _____

What is the reason you have decided to call to schedule an appointment?

_____

_____

_____

_____

_____

_____

Is there a dental benefit company you'd like us to bill for your visit?

Dental Insurance Co: _____ Phone #: _____

ID # or SSN: _____ Group Name/#: _____

Policy Holder *If Other than self* : _____

DOB: _____ / _____ / _____ Relationship: _____

Billing Address: _____

**** If we do not have your dental insurance prior to your visit we will collect for services rendered, please let us know if you'd like that estimate prior to your visit.*