Peter Lubisich IV D.M.D., M.S.
Josef W. Lubisich D.M.D., M.S.
Peter Lubisich III D.D.S.

Vancouver Pediatric Dentistry
Drs. Lubisich

Patient's Names/Birthdates _____

_____

Previous Dentist _____ Who may we thank for referring you? _____

Mother/Guardian _____ Birthdate _____

Home Address _____ City/State _____ Zip _____

How Long at current address _____ Single ❍ Married ❍ Divorced ❍ Widowed ❍

Home Phone _____ Cell Phone _____ Email _____

SS#/License# _____ Preferred method of contact: home ❍ cell ❍ email ❍ other ❍ _____

Employer _____ Phone _____ How Long _____

Address _____ City /State _____ Zip _____

Father/Guardian _____ Birthdate _____

Home Address _____ City/State _____ Zip _____

How Long at current address _____ Single ❍ Married ❍ Divorced ❍ Widowed ❍

Home Phone _____ Cell Phone _____ Email _____

SS#/License# _____ Preferred method of contact: home ❍ cell ❍ email ❍ other ❍ _____

Employer _____ Phone _____ How Long _____

Address _____ City /State _____ Zip _____

Primary Dental Insurance Co. _____ Subscriber's name _____

Phone _____ Group # _____ ID# _____

Secondary Dental Insurance Co. _____ Subscriber's name _____

Phone _____ Group# _____ ID# _____

Emergency Contact other than parent/guardian

Name _____ phone _____

Method of Payment

❍ Cash or check at appointment

❍ Insurance

❍ Public Assistance/ DSHS

❍ Credit/Debit Card

I, (please print) _____

accept responsibility for this account.

SS# _____

Driver License# _____

Signature _____

Date _____