

Stephen Lehman D.D.S.
General information

Date _____

Dr. _____
Mr. _____
Mrs. _____
Miss _____
Ms. _____
Last First Middle Pronunciation: _____

I prefer to be called: _____ Birthdate _____
Month Day Year

Residence Address _____
Number Street Residence Phone () _____

City State Zip Code Cell # () _____

Email Address _____

Preferred way of communication & messages: Home Phone Work Phone Email Cell Phone

Social Security Number _____ Insurance I.D. _____

Occupation _____ Employer _____

Employer Address _____ Work Phone _____

City _____ State _____ Zip _____

Marital Status: Married Single Divorced Widow(er) Name of Spouse _____

Last, First, Middle

Spouse's SSN _____ Spouse's Birthday _____

Occupation _____ Employer _____

Phone () _____ Work Phone () _____

Who is legally responsible, if other than patient? _____

Last First Middle

Relationship to patient _____

Address _____
Number Street City Zip Code Phone () _____

Who may we thank for referring you to our office? _____

Do you have Dental Insurance? Yes No Name of Insurance _____

Phone Number _____ Group Number _____