



RITA
MEDWID DDS, PA
DENTAL HEALTH SPA

725 S.E. Osceola Street • Suite 1
Stuart, FL 34994

Today's Date: _____

First Name: _____ Last Name _____
I prefer to be called: _____ Gender: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ SSN: _____
Marriage Status: _____ Email Address: _____
Date of Birth: _____ Driver License #: _____

Employer: _____ Occupation: _____
Address: _____ City: _____
State: _____ Zip Code: _____
How would you like us to contact you?: ☐ Cell ☐ Text ☐ Email ☐ Other
When are the best times to reach you?: _____

Whom may we thank for referring you?: _____
Other family members seen by us?: _____
Previous/Present Dentist?: _____
Date of last visit?: _____
What was done?: _____

2.Spouse Info

His/Her Name: _____ Employer: _____
Work Phone: _____ SSN: _____
Date of Birth: _____

3.In case of an emergency, is there someone who lives near you that we should contact?
Name: _____ Relationship: _____
Work Phone: _____ Cell Phone: _____ Home Phone: _____

4.Dental Insurance

Insurance Company Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Phone Number: _____ Group/Policy# _____
Insured's Name: _____ Relation: _____
Insured's DOB: _____ Insured's ID#: _____
Insured's Employer: _____

Secondary Insurance Company Name: _____
Address: _____ City: _____
State: _____ Zip Code: _____
Phone Number: _____ Group/Policy# _____
Insured's Name: _____ Relation: _____
Insured's DOB: _____ Insured's ID#: _____
Insured's Employer: _____