Dr. Shary Henderson DDS

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(248) 652-1600

| | | Welcome to o | ur Practice | | | | |
|-----------------------------|--|-----------------------|-----------------------|--------------|------------|----------------|----------------|
| | | | | | | Chart#: | |
| | | | | | | FOR | OFFICE USE ONL |
| atient Name: | | | | | | | |
| itle: | Cender: Male Female | Earnilly 6 | First Status: Married | O Single | MI | | rred Name |
| Mr/Ms/Mrs/etc | Gender: O Male O Pernale | ramily | status: O Marned | Single | Child | Other | |
| irth Date: | | | Prev. Visit: | | | | |
| mail Address: | | | | Best time to | call: | | |
| none: | - | | | | | | |
| Home | Mobile | Work | Ext | Fax | | Other | |
| Idress: | | | - | | | | |
| | Address 1 | | | | Address | 2 | |
| - | | City | | | | State | Zip Code |
| | | Employment la | nformation | | | | |
| e following is for: Ot | the patient the person responsib | le for payment | both onot appli | cable | | | |
| nployer Name: | | | | | Phor | ne: | |
| untarran Addassa. | | | | | | | |
| - | Address 1 | | - | | Addre | ess 2 | |
| - | | | - | | | | |
| | | City | | | | State | Zip Code |
| Tommay we trank for res | erring you to our practice? | | | | | | |
| an emergency who sh | ould be notified? Please enter N | ame and Phone | number below: | | | | |
| | | | | | | | |
| | | | | | | | |
| | | ponsible Party | | | | | |
| s only needs to be filled o | out if the insurance subscriber is other | r than patient, or ye | ou are the parent/gu | ardian of th | e patient | | |
| e following is for: O to | he patient's spouse O the person r | esponsible for pay | ment O both O | neither-not | applicable | | |
| me: | | | | | | | |
| | Last | First | | MI | | Preferred Name | ! |
| e:Mr/Ms/Mrs/etc | Gender: Male Female | Family S | status: Married | Single | ○ Child | Other | |
| th Date: | SS#: | | DL#: | | | | |
| ail Address: | a a mar in a construction | | в | est time to | call: | | 8 |
| one: | | | | | | | |
| Home | Mobile | Work | Ext | Fax | - | Other | |
| dress: | | | | | | | |
| | Address 1 | | | | Address | 2 | |
| | | City | | | | State | Zip Code |
| | | | | | | | |

| Primary Dental Insurance: | | | | | |
|---|---|----------|-------|-------------------|-----------------|
| Name of Insured: | | | | | - |
| | Last | | First | | |
| nsured's Birth Date: | ID#: | Group #: | | - | |
| nsured's Address: | | | | | |
| | Address 1 | | Addr | ess 2 | |
| der de entre reservante de la constante de la | City | 3.5 | | State | Zip Code |
| nsured's Employer Name: | | | | | A specifical of |
| mployer Address: | | | | | |
| | Address 1 | | Addre | ess 2 | |
| | City | | | State | Zip Code |
| atient's relationship to insured | I: O Self O Spouse O Child O Other | | | | |
| | | | | | |
| | | | 1000 | | |
| nsurance Address: | Address 1 | | Adde | | |
| | Address (| | Addre | :SS Z | |
| | City | | | State | Zip Code |
| | | | | | |
| nsurance Company Phone Num | ber: | | | | |
| | ber: | | | | |
| secondary Dental Insurance: | | | | | |
| econdary Dental Insurance: | | | First | | |
| econdary Dental Insurance: ame of Insured: | | Group #: | First | | |
| econdary Dental Insurance: ame of Insured: asured's Birth Date: | Last | Group #: | First | | |
| econdary Dental Insurance: ame of Insured: asured's Birth Date: | Last | Group #: | First | ess 2 | |
| econdary Dental Insurance: ame of Insured: asured's Birth Date: | Last | Group #: | | ess 2 | Zip Code |
| econdary Dental Insurance: ame of Insured: sured's Birth Date: | Last ID#: Address 1 City | Group #: | | | Zip Code |
| econdary Dental Insurance: ame of Insured: assured's Birth Date: assured's Address: | Last ID#: Address 1 City | Group #: | | | Zip Code |
| econdary Dental Insurance: ame of Insured: assured's Birth Date: assured's Address: | Last ID#: Address 1 City | Group #: | | State | Zip Code |
| econdary Dental Insurance: ame of Insured: assured's Birth Date: assured's Address: | Last ID#: Address 1 City Address 1 | Group #: | Addre | State | |
| econdary Dental Insurance: ame of Insured: sured's Birth Date: sured's Address: sured's Employer Name: | Last ID#: Address 1 City City | Group #: | Addre | State | Zip Code |
| econdary Dental Insurance: ame of Insured: sured's Birth Date: sured's Address: sured's Employer Name: mployer Address: | Last ID#: Address 1 City Address 1 City Self O Spouse O Child O Other | | Addre | State | |
| decondary Dental Insurance: Iame of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Imployer Address: | Last ID#: Address 1 City City | | Addre | State | |
| | Last ID#: Address 1 City Address 1 City Self Spouse Child Other | | Addre | State sss 2 State | |
| Secondary Dental Insurance: Iame of Insured: Insured's Birth Date: Insured's Address: Insured's Employer Name: Employer Address: Patient's relationship to insured Insurance Plan Name: | Last ID#: Address 1 City Address 1 City Self O Spouse O Child O Other | | Addre | State sss 2 State | |