Jay W. Dorgan, DDS, FAGD

FELLOW: Academy of General Dentistry

DDS: University of Maryland, Baltimore College of Dental Surgery, Baltimore, MD

MEMBER: American Academy of Cosmetic Dentistry, Academy of Osseointegration, American Dental Association, Pennsylvania Dental Association, Delaware–Chester County Dental Society

AWARDS: Named Top Family/ Cosmetic Dentist 2007, *Main Line Today*

ALUMNUS: L.D. Pankey Institute for Advanced Dental Education, Dawson Center for Advanced Dental Study, Seattle Institute for Advanced Dental Education

Advanced technology

- Digital radiography
- DIAGNOdent® cavity detection
- Intraoral cameras
- Tekscan

Comprehensive services

- Cosmetic dentistry
- Crowns & bridges
- Porcelain veneers
- Implants
- Bonding
- Removable partial dentures
- Advanced preventive care

Comforts & conveniences

- Flat-screen TVs
- Espresso bar
- Visa, MasterCard, American Express & Discover
- CareCredit®

JAY W. Dorgan DDS

Restorative skill.
Esthetic excellence.
Experience you can trust.

PATIENT INFORMATION

Today's Date: _____ / _____ / _____
month day year

Personal Information

Patient's Name _____

Address _____

City _____ ST _____ ZIP _____

Home Phone (_____) _____-_____

Work Phone (_____) _____-_____ Ext _____

Cell Phone (_____) _____-_____

Pager (_____) _____-_____

E-Mail _____@ _____._____

Date of Birth: _____ / _____ / _____
month day year

Employment Information

Employer _____

City _____ Occupation _____

Family Information

Name of Spouse / Parent / Guardian _____
(please circle one)

Date of Birth: _____ / _____ / _____ Social Security # _____/_____/_____
month day year

Address _____

City _____ ST _____ ZIP _____

Home Phone (_____) _____-_____

Work Phone (_____) _____-_____ Ext _____

Employer _____

City _____ Occupation _____

In case of emergency, whom shall we notify other than spouse?

Name _____ Relationship _____

Phone (_____) _____-_____

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PATIENT INFORMATION - page 2

PRIMARY INSURANCE INFORMATION

EMPLOYEE'S NAME _____

INSURANCE COMPANY'S NAME _____

INSURANCE COMPANY'S ADDRESS _____

INSURANCE COMPANY'S CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY'S PHONE (_____) _____-_____

GROUP / POLICY NUMBER _____

EMPLOYEE SOCIAL SECURITY NUMBER _____/_____/_____

BIRTH DATE _____ /_____ /_____

SECONDARY INSURANCE INFORMATION

EMPLOYEE'S NAME _____

INSURANCE COMPANY'S NAME _____

INSURANCE COMPANY'S ADDRESS _____

INSURANCE COMPANY'S CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY'S PHONE (_____) _____-_____

GROUP / POLICY NUMBER _____

EMPLOYEE SOCIAL SECURITY NUMBER _____/_____/_____

BIRTH DATE _____ /_____ /_____

Who referred you to this office? _____

Patient Acknowledgments:

I understand that I am responsible for any uninsured balance.

If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical practitioner/provider for any needed evaluation.

I have read the above:

Signature _____ Date _____

Parent or Guardian if a minor

Print Name _____

(610) 925-3222 • 127 W. Street Road, Suite 301 • Kennett Square, PA 19348 • Fax: (610) 925-3180 • www.DrDorgan.com