Michael C. Clausius DDS
8725 S Howell Ave
Oak Creek WI 53154

(414)762-0200

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.(PLEASE PRINT).

Patient is : ☐ Ins Policy Holder ☐ Adult 18 or older Chart # ____ FOR OFFICE USE ONLY

☐ Responsible Party ☐ Child

Patient Name: ____ Last ____ First ____ MI ____ Preferred Name

Title: ____ Mr/Ms/Mrs/etc Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Birth Date: ____ SS#: ____ Drivers License #: ____

Address: ____ ____

____ City ____ State ____ Zip Code

Email Address: ____ Best time to call: ____

Phone: ____ Home ____ Work ____ Ext ____ Mobile 1

Preferred appointment times:

☐ Mom ☐ Tue ☐ Wed ☐ Thru ☐ Fri

☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time

EMERGENCY CONTACT: 2 ____

SPOUSES WORK#: 3 ____

MOMS WORK#: 4 ____

DADS WORK#: 5 ____

Student status: ☐ Full time ☐ Part time

Name of school: ____

Which is the best # to contact you at: ____

Patient Employment Information

Employment status: ☐ Full Time ☐ Part Time ☐ Retired

Employer Name: ____ Phone: ____

Address: ____ ____

____ City ____ State ____ Zip Code

Whom may we thank for referring you to our practice?

☐ Dental office ☐ Insurance company ☐ Welcome Wagon ☐ Internet ☐ Other

☐ Work ☐ Yellow pages ☐ Food store ☐ Patient

Name of person, office, or other source referring you to our practice

____

Michael C. Clausius DDS
8725 S Howell Ave
Oak Creek WI 53154

(414)762-0200

Spouse or Responsible Party Information

(PLEASE PRINT)

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither- not applicable

Name: ______ Last ______ First ______ MI ______ Preferred Name

Title: ______ Mr/Ms/Mrs/etc **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Birth Date: ______ **SS#:** ______ **Drivers License #:** ______

Address: ______ ______

______ City ______ State ______ Zip Code

Email Address: ______ **Best time to call:** ______

Phone: ______ Home ______ Work ______ Ext ______ Mobile 1

☐ Responsible Party is also a Policy Holder for Patient

☐ Primary Insurance Policy Holder

☐ Secondary Insurance Policy Holder

Spouse or Responsible Party Employment Information

Employment status: ☐ Full Tme ☐ Part Time ☐ Retired

Employer Name: ______ **Phone:** ______

Address: ______ ______

______ City ______ State ______ Zip Code

Primary Insurance Information

(PLEASE PRINT)

Primary Dental Insurance:

Name of Insured: ______ Last ______ First ______ MI

Insured's Birth Date: ______ ID#: ______ Group#: ______

Insured's Address: ______ ______

______ City ______ State ______ Zip Code

Insured's Employer Name: ______ Phone: ______

Employer Address: ______ ______

______ City ______ State ______ Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: ______ Phone: ______

Insurance Address: ______ ______

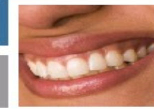
______ City ______ State ______ Zip Code

Primary Medical Insurance:

Name of Insured: ______ Last ______ First ______ MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: ______ Phone: ______



Secondary Insurance Information

(PLEASE PRINT)

Secondary Dental Insurance:

Name of Insured: ______ Last ______ First ______ MI

Insured's Birth Date: ______ **ID#:** ______ **Group#:** ______

Insured's Address: ______ ______

______ City ______ State ______ Zip Code

Insured's Employer Name: ______ **Phone:** ______

Employer Address: ______ ______

______ City ______ State ______ Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: ______ **Phone:** ______

Insurance Address: ______ ______

______ City ______ State ______ Zip Code

Secondary Medical Insurance:

Name of Insured: ______ Last ______ First ______ MI

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: ______ **Phone:** ______