Adult & Cosmetic Dentistry
Rochelle H. Lindner, D.M.D.
Lesleyann M. Splagounias, D.M.D.
David J. Shane, D.M.D.
Heidi Lindner Kurland, M.S., D.M.D.

Orthodontics
Gary S. Lindner, D.M.D., D.M.Sc. -Board Certified
Tracy E. Pogal-Sussman, M.S., D.M.D. -Board Certified

Lindner DENTAL
ASSOCIATES, P.C.

*DATE*_____

ADULT PATIENT INFORMATION

To be filed in patient's electronic chart

Name_____ Address _____
Last First Middle Number Street

City_____ State_____ Zip_____ Male_____ Female_____

Date of Birth_____ Social Security # _____

Single_____ Widowed_____ Married_____ Spouse's Name _____

Occupation_____ Place of Employment_____

Email_____ Home Phone_____ Cell Phone _____

Business Address_____ Business Phone _____

Spouse's Employment_____ Business Address_____

Children's Names _____

Emergency Contact_____ Emergency Phone_____

Previous Dentist_____ Address_____ Phone _____

Whom may we thank for referring you? _____

Do you have dental insurance? Y___ N____ Name of Dental Insurance Company _____

All information is correct to the best of my knowledge.

Signature_____ Date _____