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Personal Information Update

Name: _____ Date: _____

1. Has your name changed since your last visit? _____ yes _____ no
If yes, what was the prior name? _____
What name do you use for insurance (if different than above)? _____

2. If you have a new or different address since your last visit, please indicate below:

3. Has your marital status changed? _____ yes _____ no

4. Has your telephone number changed? _____ yes _____ no

Home number: _____

Work number: _____

Cellphone number: _____

5. Has your employment changed? _____ yes _____ no

If yes, please indicate your new employer name and address:

6. Have you changed insurance companies? _____ yes _____ no

If yes, please indicate your new insurance information:

Primary: _____ Secondary: _____

Group Number(s): _____ Group Number(s): _____

Subscriber Number(s): _____ Subscriber Number(s): _____

7. Who is responsible for the bill? _____

Signature of PATIENT, PARENT or GUARDIAN: _____ Date: _____