Richard M. Gray, DDS
2032 Lowe St, Suite 100
Fort Collins, CO 80525
(970) 221-3020

Patient Information

Patient Name: _____ Today's Date: _____

Address: _____ City/State/Zip: _____

___Male ___Female ___Married ___Single ___Child ___ Other_____

Social Security Number: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____Work Phone._____

Email Address: _____ Employer: _____

How did you hear about us? _____

Person to contact in case of emergency: _____

Please note: If you do not wish to receive **text message or email reminders** and confirmations for your appointments, simply opt out of these services when you receive the introductory email or text message. If you have questions or would like to change your preferences, please speak to the office manager.

Responsible Party
(if other than yourself)

Name: _____ Date of Birth: _____

Address: _____ City/State/Zip_____

___ Male ___Female ___Spouse ___Son/Daughter ___Parent ___Other_____

Social Security #:_____

Cell Phone: _____ Home Phone: _____ Work Phone:

Insurance Information

Primary Insurance

Name of primary insurance holder and employer: _____

Primary insurance holder: date of birth: _____ Social Security Number:_____

Subscriber or Member #:_____ Group #:_____

Electronic Claims Payer #:_____

Relationship to insured: __Self __Spouse __Child __Other

Dental Claims Address: _____City/State: _____ Zip: _____

Dental Insurance Carrier's Phone Number: _____

If you have a secondary insurance carrier, please speak to the office manager.