Jeffrey M. Keating, D.M.D.
Patient Acquaintance Form

Name:_____Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Cell Phone:_____ Sex(M/F):_____MaritalStatus:_____

Birthdate:_____ Social Sec #:_____ Email:_____

Name of Responsible Party:_____

Billing Address:_____

Insurance: (Y/N)_____ Employer name:_____

Ins Co Name:_____ Ins ID#:_____ Group#:_____

Referred By:_____

Does Your Medical History Include Any Of The Following:

1. **List any medications you are presently taking:_____**
2. **Pharmacy Name: _____**
3. **Pharmacy Number:_____**
4. **Emergency Contact Name:_____**
5. **Emergency Contact Number:_____**

_____ _____

Patient Signature **Date**

*********PLEASE NOTE, THERE IS A $50 CHARGE FOR APPOINTMENTS CANCELED WITH LESS THAN 24 HOURS NOTICE**************