J. Robert Hendricks, DMD, MPH
Brentwood Dental Specialists, LLC
1642 Westgate Circle
Brentwood, TN 37027
(615) 373-9889

Patient Information

Date: ____/____/____ Patient Name: _____ _____ _____
Last First Middle

Address _____ _____ _____ _____
Street City State Zip

Nickname: _____ Birthdate: ____/____/____ Age: _____ Sex _____ Social Security # _____-_____-_____

Dentist Name: _____ Date of last dental exam: ____/____/____
Address: _____ Phone # _____

Who referred you to our office? _____ Purpose of today's visit? _____

Parent/Guardioan Name: _____
Address (If different): _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone _____ Work Phone: _____

Insurance Information

Insured's Name: _____ _____ _____ Social Security # _____/_____/_____
Last First Middle

Dental Insurance Company _____ Group # _____ ID # _____
Insured's Place of Employment: _____ Occupation: _____

Do you have secondary coverage? (circle one) YES NO

Insured's Name: _____ _____ _____ Social Security # _____/_____/_____
Last First Middle

Dental Insurance Company _____ Group # _____ ID # _____
Insured's Place of Employment: _____ Occupation: _____

_____ _____
Signature of Parent/Guardian Date