EASTERN SHORE ENDODONTICS
TRES H. MANASCO, D.M.D., P.C.

ACQUAINTANCE SLIP

Patient's Name _____ Date of Birth _____

Address _____ Phone _____

City & State _____ Zip Code _____

Employer _____ Dept. _____

Employer's Address _____

_____ Phone _____

Your Social Security # _____

Does your employer provide Dental Insurance? _____

If so, Name of Insurance Company? _____

Policy # _____

◆ ◆ ◆ ◆ ◆

Spouse's or parent's Name _____

Employed by _____ Dept. _____

Employer's Address _____

_____ Phone _____

Social Security # _____

Does this employer provide Dental Insurance? _____

If so, Name of Insurance Company? _____

Policy # _____

Birthdate of Insured _____

PLEASE TURN TO BACK OF THIS SHEET TO ANSWER THE REQUIRED MEDICAL QUESTIONS