

NEW PATIENT INFORMATION FORM

NAME (first middle last): _____ TITLE: _____ SEX: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ LICENSE NO: _____ SS NO: _____

WORK PHONE: _____ CELL PHONE: _____ PAGER: _____

DOB: ____ / ____ / ____ MARITAL STATUS: _____ PREFERRED NAME: _____

EMPLOYER NAME: _____ ADDRESS: _____

E-MAIL ADDRESS: _____ PATIENT REFERRED BY: _____

If full time student, NAME OF COLLEGE: _____

RELATIVES/EMERGENCY CONTACTS

SPOUSE/PARENT NAME: _____ SS NO: _____

EMPLOYER NAME: _____ WORK PHONE: _____

NEAREST RELATIVE: _____ PHONE: _____

PERSON TO NOTIFY IN EMERGENCY: _____ PHONE: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS NO: _____ DOB: _____ GROUP NO: _____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS NO: _____ DOB: _____ GROUP NO: _____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

RESPONSIBLE PARTY FOR PATIENT:

Name and Address: _____

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that I am responsible for all fees for dental services rendered. I accept full financial responsibility for all charges not covered by insurance.

Signature: _____