

NEW PATIENT INFORMATION

Date _____

Account # _____

Patient Information

Patient's Name _____ Nickname _____

Date of Birth _____ Sex _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Mother's Name _____ Father's Name _____
(Patient under age of 18) (Patient under age of 18)

Name of any family members examined or treated in this office _____

Name of General Dentist _____

Who may we thank for referring you to our office: _____

Responsible Party Information (Party to be billed)

Name _____ Marital Status _____

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouses Name _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Work Phone _____

Insurance Information

Policyholder's Name _____ Policyholder's Birthdate _____

Relationship to patient _____

Insurance Company _____ Group No. _____ Social Security No. _____

Insurance Co. Address _____

Policyholde's Employer _____

Do you have dual coverage? Yes No If yes, complete the following:

Policyholde's Name _____ Policyholde's Birthdate _____

Relationship to patient _____

Insurance Company _____ Group No. _____ Social Security No. _____

Insurance Co. Address _____

Policyholde's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

Signature (Parent's signature if minor) _____