New Patient Information

ABOUT YOU

Name: ____________________________________ Prefer to be called: __________________Male___ Female___

Single____ Married____ Child____ Birth Date: ___/___/___ Social Security #:_____-____-______

Home Address: ________________________________ City: ____________ State: _____ Zip: __________

Home Phone: __________________ Cell Phone: ____________________Work Phone___________________

Email Address: ______________________________@________________________.com

How would you like to be confirmed for future appointments? (Circle one) Text, Email or Phone call

Employer: ________________________________ Years employed: ____ Occupation: _________________

Employers Address: ________________________ City: _______________ State: ____ Zip:__________

PERSON RESPONSIBLE FOR ACCOUNT-(IF DIFFERENT FROM ABOVE)

Name: ____________________________ Birth Date: ___/___/___ Relation: __________________

Billing Address: _________________________ City: _____________ State: ____ Zip: __________

Phone #:___________________________ Social Security #:______-____-_______

Employer: ___________________ Year's employed: _____ Work Phone #:________________________

SPOUSE INFORMATION

Name: _________________________ Birth Date: ___/___/___ Phone #:__________________________

Employer: ____________________________ Occupation: ______________________________________

DENTAL INSURANCE INFORMATION

Primary Insurance:

Insurance Co. Name: ___________________ ID#___________________ Group #__________________

Subscriber: ____________________________ Birth Date: __/__/__ Relation: ____________________

Insured's Employer: ____________________________ Social Security#______-____-______

Secondary Insurance:

Insurance Co. Name: _______________________ ID#:___________________ Group #:_____________

Subscriber: _________________________________ Birth Date: __/__/__ Relation: ______________________

Insured's Employer: ________________________ Social Security #:______-____-______