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 _____ Cell Phone _____
E-Mail _____ Birthdate _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
Spouses Name _____ Relationship to Patient _____
Employer _____ Occupation _____ No. Years Employed _____
E-Mail _____ Birthdate _____ Work Phone _____ Cell Phone _____

Insurance Information

Policyholder's Name _____ Policyholder's Birthdate _____
Relationship to patient _____
Insurance Company _____ Group No. _____ Subsciber I.D. _____
Insurance Co. Address _____
Policyholder's Employer _____
Do you have dual coverage? Yes ☐ No ☐ If yes, complete the following:
Policyholder's Name _____ Policyholder's Birthdate _____
Relationship to patient _____
Insurance Company _____ Group No. _____ Subsciber I.D. _____
Insurance Co. Address _____
Policyholder's Employer _____

Emergency Information

Name of nearest relative not living with you _____
Complete Address _____
Phone _____

Signature (Parent's signature if minor) _____