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)______________________

01-14