

NEW PATIENT INFORMATION

Please print clearly.

Patient Information

DATE CELL S.S.#

NAME PREFERRED NAME

Address Last First MI APT # ZIP

CITY STATE BIRTHDATE AGE

SEX Male Female MARITAL STATUS Single Married Widowed Separated Divorced

EMAIL EMPLOYED BY

EMERGENCY CONTACT PHONE

HOW DID YOU HEAR ABOUT US?

Person Financially Responsible for Account

NAME RELATIONSHIP TO PATIENT

ADDRESS APT # ZIP

CITY STATE BIRTHDATE SS#

EMPLOYED BY

Primary Insurance (If None, Leave Blank)

SUBSCRIBER NAME RELATIONSHIP TO PATIENT

SUBSCRIBER ADDRESS APT # ZIP

CITY STATE BIRTHDATE SS#

SUBSCRIBER EMPLOYER BUSINESS PHONE

INSURANCE COMPANY GROUP # MEMBER ID #

Secondary Insurance (If None, Leave Blank)

SUBSCRIBER NAME RELATIONSHIP TO PATIENT

SUBSCRIBER ADDRESS APT # ZIP

CITY STATE BIRTHDATE SS#

SUBSCRIBER EMPLOYER BUSINESS PHONE

INSURANCE COMPANY GROUP # MEMBER ID #

Authorization

I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the release of information necessary to process insurance claims. I understand that I am financially responsible for all charges not covered by insurance and for any balance remaining on my account.

SIGNATURE DATE