



New Patient Information

Welcome to our office! Help us get to know you by completing the following form to the best of your ability!

Patient Info (or responsible party):

First Name: _____	Last Name: _____	Middle Initial: _____
Preferred Name: _____		
Mailing address: _____	Suite/Apt #: _____	
City: _____	State: _____	Zip Code: _____
Cell Phone: _____	Home phone: _____	
E-mail address: _____		
Birth Date: _____	Social Security #: _____	
Emergency Contact Name: _____ Emergency Contact Phone #: _____		
Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Child <input type="checkbox"/> Other		
Who can we thank for referring you to our office?		
<input type="checkbox"/> Google <input type="checkbox"/> Mailer <input type="checkbox"/> Patient _____ <input type="checkbox"/> Other _____		

Insurance Information:

Primary Dental Insurance:			
Subscriber Name: _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Subscriber ID: _____	Social Sec #: _____	Group ID: _____	
Insured Birthdate: _____	Subscriber Employer: _____		
Secondary Dental Insurance:			
Subscriber Name: _____	Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other		
Subscriber ID: _____	Plan Name: _____	Group ID: _____	
<input type="checkbox"/> No Dental Insurance			

Communication:

We frequently communicate via automated texts, emails, and phone calls for appointment reminders. If you would prefer for us <u>NOT TO</u> contact you by any of those methods, please indicate so here: <input type="checkbox"/> Text <input type="checkbox"/> Phone <input type="checkbox"/> Email			
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Signature of Patient (or responsible party): _____

Date: _____