New Patient Information

Name: ______________________________ BirthDate: ______________________

Email Address ________________________ Male___ Female_____

SocialSecurity No: ______________________ Marital Status: m ___ s___

Mailing Address: ____

City: ______________________________State: ____________Zip: __________

Phone: _______________Cell: ______________ Work: ________________________

preferred method of contact text_______ email_________other________________________

Person Responsible For Account: ______________________Birth Date: _____________

Mailing Address if different ____

City: ______________________________State: ____________Zip: __________

Emergency Contact: ______________________Phone: ______________________

Previous Dentist: _________________________ Phone: ______________________

Last Dental Cleaning: ______________________Were X-rays taken? _______________

Whom may we thank for referring you?___________________________________

Primary Dental Insurance

Insurance Company: ______________________Employer: ______________________

Address: ______________________________ City: __________________________

State: ______________Zip: ________________ Phone: ________________________

Name of Insured: ____________________Birth Date: __________Group#___________

Social Security Number or Alternate ID #_________________________________

Relationship to Patient____