N E W P A T I E N T I N F O R M A T I O N F O R M

LAST NAME: _____ TITLE: _____ FIRST NAME: _____

MIDDLE NAME: _____ NICK NAME: _____

HOME ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ SS#: _____-_____

DOB: _____/_____/_____ MARITAL STATUS: _____ SEX: _____

EMPLOYER NAME AND ADDRESS: _____

REFERRING DR: _____ REFERRING PT: _____

MEDICAL ALERTS: _____

PRIMARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: _____-_____-_____ DOB: _____/_____/_____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

SECONDARY INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

RELATION TO PATIENT: _____ SS#: _____-_____-_____ DOB: _____/_____/_____

EMPLOYER NAME AND ADDRESS: _____

INSURANCE COMPANY NAME AND ADDRESS: _____

GROUP #: _____ FAMILY YRLY DEDUCT: _____ INDIV YRLY DEDUCT: _____

RESPONSIBLE PARTY FOR PATIENT:

INSURANCE: In order to prevent misunderstandings about dental insurance, we wish our patients to know that ALL DENTAL SERVICES FURNISHED ARE CHARGED DIRECTLY TO THE PATIENT & THAT PATIENTS ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF BILLS REGARDLESS OF INSURANCE COVERAGE.

APPOINTMENTS: If unable to keep appointments, kindly give 48 hours notice, otherwise we reserve the right to charge for time appointed.

Name and Address: _____

I have read and understood the above:

Signature: _____

Please write any additional insurance information on the back of this form - Thank You!