New Patient Information Form

Please Print:

Name (last, first, middle):____ Title:____________
Address:_____________________________City:______________ State:_________Zipcode:_________
Preferred Name:____________________SS No.:______________________D.O.B.:_______________
Home Phone:_________________________Martial: S/M/W/D Referring Doctor:_______________
Work Phone:_________________________Sex male/female Referring Patient:_______________
Cell Phone:_________________________ Email Address____________________________________

Medical Alerts____

Primary Dental Insurance Carrier

Subscriber's Name:_____________________________________Relationship to Patient______________
Address:_____________________________City:______________ State:_________Zipcode:_________
Employer:___________________________SS No.:______________________D.O.B.: ______________
Address:_____________________________City:______________ State:_________Zipcode:_________
Insurance Co.:________________________ ID No.:________________________Group No.:_________
Address:_____________________________City:______________ State:_________Zipcode:_________
Insurance Co. Phone:________________Benefit Year:_______Ind. Deductible:___Family Deductible:____

Primary Medical Insurance

Subscriber's Name:_____________________________________Relationship to Patient______________
Address:_____________________________City:______________ State:_________Zipcode:_________
Insurance Co.:________________________ ID No.:________________________Group No.:_________
Address:_____________________________City:______________ State:_________Zipcode:_________
Insurance Co. Phone:________________Benefit Year:_______Ind. Deductible:___Family Deductible:____

Responsible Party - Consent

The undersigned hereby authorizes the Doctor, after consultation with patient (or parent, if minor), to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicted in connection with(Name of Patient):_________________________ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

Name (last, first, middle):____ Title:____________
Address:_____________________________City:______________ State:_________Zipcode:_________

Signature: ____Date: _________________________