

NEW PATIENT INFORMATION

NAME _____ TITLE _____
HOME ADDRESS _____ ZIP _____
PREFERRED NAME _____ SS NO _____ DOB ___/___/___
PHONE home _____ work _____ cell _____ E-MAIL _____
SEX M/F RESPONSIBLE PARTY NAME _____
MARITAL S/M/D/W WHO REFERRED YOU? _____

DENTAL INSURANCE

	PRIMARY	SECONDARY
SUBSCRIBER'S NAME	_____	_____
SUBSCRIBER'S DOB	_____	_____
SUBSCRIBER'S SS NO	_____	_____
EMPLOYER	_____	_____
INSURANCE COMPANY	_____	_____
INSURANCE PHONE	_____	_____
SUBSCRIBER ID NO	_____	_____

I understand that payment is expected when services are rendered unless other arrangements are made in advance. I authorize the dentist to release any information, including diagnosis and treatment, to third party payers.

Repeated cancellations with less than 24 hours notice will result in a \$50.00 charge.
We appreciate your cooperation!

Signature of patient, or parent if patient is a minor.