NEW PATIENT INFORMATION FORM

NAME: _____
LAST FIRST MIDDLE

NICK NAME: _____ DOB: ____/____/____ SS#: _____-_____-_____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

HOME ADDRESS: _____

MARITALSTATUS: ❍SINGLE ❍MARRIED ❍DIVORCED ❍WIDOWED ❍SEPARATE SEX: ❍FEMALE ❍MALE

EMPLOYER NAME AND ADDRESS: _____

WHOM MAY WE THANK FOR REFERRING YOU?: _____

PRIMARY E-MAIL ADDRESS (For T-Link Use):_____

PERSON TO CONTACT IN CASE OF EMERGENCY: _____ PHONE: _____

PRIMARY DENTAL INSURANCE COVERAGE

SUBSCRIBER NAME AND ADDRESS: _____

PHONE: _____ RELATION TO PATIENT: _____ SS#: ____-____-____

DOB: ____/____/____ EMPLOYER NAME AND ADDRESS: _____

EMPLOYER PHONE: _____ INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY PHONE: _____ GROUP #: _____

IF PATIENT IS A STUDENT, NAME OF SCHOOL/COLLEGE: _____

RESPONSIBLE PARTY FOR PATIENT

I understand and agree that regardless of my insurance state, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Name, Address and (if different from above): _____

Phone: _____ SS#: _____ DOB: ____/____/____

Signature: _____ **Date:** _____

Signature and Date of patient or guardian if different from responsible party: _____

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