New Patient Information

Please fill in the following information. Your answers are for our records only and will be kept strictly confidential subject to applicable laws.

General Information

First Name - Patient *

Middle Name

Last Name - Patient *

Nickname/Preferred Name

Patient Date of Birth *

Gender

- Male
- Female
- Other

Email Address

Preferred Contact Method

How did you hear about our office? *

- Referral
- Google
- Facebook
- Instagram
- Other

Do you consent to digital communication? (Ex. Appointment Reminders, Electronic Statements, etc.) *

- Yes
- No

Contact Information

Mobile # *

(___) ___-____

Home #

(___) ___-____

Work #

(___) ___-____

Patient Mailing Address

Line 1

Line 2

City

State

Zip Code

Country

USA

Is patient's mailing address the same as patient's billing address?

- Yes
- No

Guarantor/Guardian/Parent Information (If applicable)

Responsible Party Name

Relationship to Patient

Responsible Party Date of Birth

Cell Phone Number

Emergency Contact Information

Emergency contact

Emergency #

(___) ___-____

Relationship to Patient

Insurance Information

Do you have dental insurance benefits that you will be using?

- Yes
- No

Employer

Social Security Number

Please supply a copy of your current dental insurance card to office.

Print name *

Date

I agree that the information provided in this form is correct to the best of my knowledge.

Signature *

Clear