



NEW PATIENT FORM

PLEASE COMPLETE ALL ITEMS ON THIS FORM
AND RETURN TO RECEPTIONIST

Patient Name _____ Date of Birth _____
If Patient is child, Parent's Name _____
Street Address _____ Apt _____
City _____ State _____ Zip _____ Cell Phone (____) _____
Home Telephone (____) _____ Work Phone (____) _____
Name of Employer _____ Email Address _____
SS # of Patient _____ Driver's License # _____
Responsible Party _____

Dental Insurance Yes No :

Policy Holder _____ Employer _____
Ins Company _____ Phone # _____ Group # _____
Insured: SS# _____ Date of Birth _____

Name of Spouse _____ Name of Spouse's Employer _____
Names and ages of Children _____
Name of Nearest Relative Not Living With You? _____
Address _____ Phone (____) _____ Relationship _____

Do you or have you ever had any of the following:

- Anemia Yes No
- Diabetes..... Yes No
- Abnormal Heart Condition Yes No
- Abnormal Blood Pressure () High or () Low Yes No
- Abnormal Bleeding from a Cut Yes No
- Rheumatic Fever..... Yes No
- Hepatitis..... Yes No
- Any Contact with A.I.D.S. Yes No
- Allergic to Any Medications Yes No

If yes: _____

Are you taking medication? _____ If so, Name _____

Name of Physician _____ Date of last Physical _____

Are you under the care of a physician now? _____

Explain _____

Other Physical Conditions _____

PLEASE READ CAREFULLY:

I authorize the doctor to perform any and all forms of treatment that may be indicated in connection with the dental care of the patient above and to choose and employ such assistance as he sees it fit. I understand that prior to treatment, full explanation of the procedures(s) involved will be given by the doctor and/ or his staff. I agree to pay for all services rendered at the time of treatment unless prior arrangements have been made. I understand the total balance for all services is my responsibility, including any remaining after insurance co-payment (1.5% per month charge will be applied to any remaining balance after 60 days from service date).

Signed _____ Date _____

Relationship to Patient _____

How did you hear about our office?
