NEW PATIENT INFORMATION

Patient's Name: | M.I. | Preferred Name | Date of Birth:

Whom may we thank for referring you to our office?

Best way to confirm your appointments: ☐ Text ☐ Email ☐ Call

Cell Phone #: | Email Address: | Home Phone #:

If under age 18, please list the person responsible for the account:

Name: | Address:

Do you have dental insurance? (Circle One): YES NO

Primary Dental Insurance

Policy Holder's Name: | Policy Holder's SS# | Policy Holder's Date of Birth:

Policy Holder's Employer: | Relationship to Patient

Insurance Company Name: | Group #: | ID#:

Insurance Company Address: | City, State, Zip | Ins. Company Phone #

Secondary Dental Insurance

Policy Holder's Name: | Policy Holder's SS# | Policy Holder's Date of Birth:

Policy Holder's Employer: | Relationship to Patient

Insurance Company Name: | Group #: | ID#:

Insurance Company Address: | City, State, Zip | Ins. Company Phone #

Previous Dentist's Name: | Date of Last Visit:

Previous/Current Orthodontist's Name: | Date of Last Visit:

If your wisdom teeth have been extracted, name of Oral Surgeon: | Date/Year:

Do you have any dental concerns? If yes, please explain.

What, if anything, would you change about your smile?

I acknowledge that I have received a copy of this office's Notice of Privacy Practices. _____

Signature of Patient or Guardian

PAYMENT IS DUE AT TIME OF SERVICE

I understand that I am responsible for payment at time services are rendered and am also responsible for paying any co-payment and deductible that my insurance does not cover. If I do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.75% on the balance then unpaid and owed will be assessed each month. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and authorize the use of this signature on all my insurance submissions, whether manual or electronic.

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Signature of Patient or Guardian **Date**