NEW PATIENT INFORMATION

DATE _____ DATE OF BIRTH _____

PATIENT'S NAME _____
(Last) (First) (M.I.)

HOME ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY # _____ CELL PHONE _____

E-MAIL ADDRESS _____

WHOM SHALL WE THANK FOR YOUR REFERRAL? _____

ARE YOU MARRIED? Y ___ N ___ SPOUSE'S NAME _____

CHILDREN'S NAME(S) AND AGES _____
_____

OCCUPATION _____

IF RETIRED, PREVIOUS OCCUPATION _____

EMPLOYER _____

PERSON RESPONSIBLE FOR ACCOUNT _____

ADDRESS _____

ARE YOU COVERED BY DENTAL INSURANCE? Y ___ N ___
IF SO, PLEASE PROVIDE US WITH THE NAME AND ADDRESS OF YOUR INSURANCE COMPANY.

NAME OF INSURANCE COMPANY _____

ADDRESS OF INSURANCE COMPANY _____

NAME AND SOCIAL SECURITY NUMBER OF THE POLICY HOLDER _____
_____

DATE OF BIRTH OF POLICY HOLDER _____

GROUP INSURANCE NUMBER _____

IF YOU ARE COVERED BY MORE THAN ONE DENTAL INSURANCE, PLEASE PROVIDE US WITH THE NAME OF SECONDARY INSURANCE COMPANY _____
_____

IN WHOSE NAME IS THIS POLICY? _____

GROUP INSURANCE NUMBER _____

Thank you for providing us with this financial information.

We invite you to discuss with us any questions regarding our services and we are willing to work out payment plans for you if needed. In order to reduce billing costs, we require payment in full for all services rendered at the time of your visit, unless other arrangements have been made with the business manager. We will accept payments from your primary insurance company when we know what amount they will cover, but will require you to make our estimated portion of your co-payment at the time of service.

I also authorize the provider to release any information required to process insurance claims. I agree to pay any portion of my account not paid by my primary insurance company within 60 days of the date of service.

Signature _____ Date _____/_____/_____

ف Adult Patient ف Parent or Guardian ف Spouse