

NEW PATIENT FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Patient Information

Date: _____

Name: _____

Home Phone: _____ Cell Phone: _____

E-Mail Address: _____

Address: _____

Street Address

City

State

Zip

How long have you been living at this address? _____

Employer: _____

Occupation: _____

Social Security Number: _____

Date of Birth: _____

Sex: ☐ Male ☐ Female

Height: _____

Weight: _____

Marital Status:

☐ Never Married ☐ Married ☐ Domestic Partnership ☐ Divorced ☐ Widowed

Emergency Contact Information:

Name: _____

Relation: _____

Emergency Phone: _____

What brings you to our office today? _____

Who referred you to our office?

Dental Insurance Information (Primary Carrier)

Insured's Name

Insurance Company

Insurance Company Address City, State, Zip

Insured's Employer

Insured's Social Security Number ID Number Group Number

**A copy of your insurance card is required.