**New Patient Form**

# **Patient Information – Fields with an \* are required**

## **First Name\***

## **Middle Name**

## **Last Name\***

## **Preferred Name**

## **Date of Birth\***

## **Gender\***

## **Marital Status**

## **Social Security Number**

## **Street Address\***

## **Street Address 2**

## **City\***

## **State\***

## **ZIP Code\***

## **Driver's License**

## **Home Phone**

## **Mobile Phone\***

## **Email\***

# **Primary Insurance Information**

If you have Dental Insurance, please complete this section as thoroughly as possible so we can minimize your wait time! You can also text us a picture of your Insurance Card and Driver’s License and we will be ready for your visit!

## **Policy Holder Name**

## **Insurance Company Name**

## **Insurance Company Street Address**

## **Insurance Company Street Address 2**

## **Insurance Company City**

## **Insurance Company State**

## **Insurance Company ZIP Code**

## **Insurance Id**

## **Group #**

## **Rx #**

## **Policy Holder Social Security Number**

## **Spouse Name**

## **Spouse Social Security Number**

## **Relationship to Patient**

# **Insurance Financial Resposibility**

Financial Responsibility for Insurance Patients

The oﬃce will make every eﬀort to accurately estimate your out of pocket expense for your visit. However, we have no control over your insurance company, available beneﬁts or what they will pay. Any amount that is not paid or otherwise rejected by your insurance will be the patients responsibility. We ask that the full balance be paid within 30 days of the work being completed or it will be turned over to a collection agency. If you need to discuss alternative payment arrangements, please speak with the oﬃce staﬀ prior to the procedure.

If using Dental Insurance please conﬁrm

# **Secondary Insurance Information**

## **Policy Holder Name**

## **Insurance Company Name**

## **Insurance Company Street Address**

## **Insurance Company Street Address 2**

## **Insurance Company City**

## **Insurance Company State**

## **Insurance Company ZIP Code**

## **Insurance Id**

## **Group #**

## **Rx #**

## **Policy Holder Social Security Number**

## **Spouse Name**

## **Spouse Social Security Number**

## **Relationship to Patient**

# **Medical History**

## **Are you allergic to any medications?**

## **Do you have, or have you ever had, any medical conditions?\***

# **Medications**

## **List Current Medications \***

## **Female only Conditions**

# **Signature Date**

## **Signature\***