Marc Craig D.M.D.
General Dentistry

New Patient Information

ABOUT YOU

Name: _____ Prefer to be called: _____Male___ Female___

Single____ Married____ Child____ Birth Date: ___/___/___ Social Security #:_____-____-_____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ ___Work Phone_____

Email Address: _____@_____.com

How would you like to be confirmed for future appointments? (Circle one) Text, Email or Phone call

Employer: _____ Years employed: ____ Occupation: _____

Employers Address: _____ City: _____ State: ____ Zip:_____

PERSON RESPONSIBLE FOR ACCOUNT-(IF DIFFERENT FROM ABOVE)

Name: _____ Birth Date: ___/___/___ Relation: _____

Billing Address: _____ City: _____ State: ____ Zip: _____

Phone #:_____ Social Security #:_____-____-_____

Employer: _____ Year's employed: _____ Work Phone #:_____

SPOUSE INFORMATION

Name: _____ Birth Date: ___/___/___ Phone #:_____

Employer: _____ Occupation: _____

DENTAL INSURANCE INFORMATION

Primary Insurance:

Insurance Co. Name: _____ ID#_____ Group #_____

Subscriber: _____ Birth Date: __/__/__ Relation: _____

Insured's Employer: _____ Social Security#_____-____-_____

Secondary Insurance:

Insurance Co. Name: _____ ID#:_____ Group #:_____

Subscriber: _____ Birth Date: __/__/__ Relation: _____

Insured's Employer: _____ Social Security #:_____-____-_____