NEW PATIENT FORM

PERSONAL INFORMATION (CONFIDENTIAL)					
Last Name First Name Middle Initial			Date of Birth	Gender	Social Security Number
Street Address City State Zip				Home/Cell Phone	
Marital Status (please check one) ☐ M ☐ S ☐ D ☐ W ☐ Under 18		Email Address		Work Phone	
Employer & Employer's Address				Occupation	
Spouse's Last Name First Name Middle Initial			Spouse's Date of Birth	Spouse's Cell Phone	
Spouse's Employer and Employer's Address				Spouse's Work Phone	
Emergency Contact Name and Relationship (other than spouse)				Emergency Contact Phone	
How did you hear about us?					

INSURANCE AND FINANCIAL INFORMATION		
Subscriber Name (Primary Insurance)	Subscriber Date of Birth	Subscriber ID Number or Social Security
PRIMARY Insurance Carrier Name	Insurance Carrier Address	
Group Name & Number	Patient Relationship to Subscriber	Insurance Carrier Phone
Subscriber Name (Secondary Insurance)	Subscriber Date of Birth	Subscriber ID Number or Social Security
SECONDARY Insurance Carrier Name	Insurance Carrier Address	
Group Name & Number	Patient Relationship to Subscriber	Insurance Carrier Phone

I consent to be a patient and agree to radiographic and clinical examination. During the course of treatment, I may undergo procedures in all phases of dentistry including periodontics, oral surgery, endodontics, fixed and removable prosthodontics, implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.

I will provide a thorough and complete medical history, supply a full list of my medications with dosages, and consent to my dentist communicating with my other medical practitioners to inquire about any aspect of my health history. I agree to update this information periodically, or as needed.

I understand no guarantees can be made about treatment outcomes, restoration longevity, or prognosis. I understand that any branch of medicine, including dentistry, can involve unanticipated results. I understand my treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I may be unsure about.

Signature_____ Date _____