

NEW PATIENT INFORMATION

We are committed to providing you with the best service possible. In order to help us serve you better, we appreciate you taking the time to complete this confidential questionnaire. If you have any questions or need assistance, please don't hesitate to ask us – we will be happy to help.

Whom may we thank for referring you or how did you hear about us? _____

ABOUT YOU

Male Female

Name: _____ I prefer to be called: _____

Single Married Child Other Birth Date: ___/___/___ Age: ___ Social Security #: _____

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

Home Phone: () _____ Mobile/Cell Phone: () _____ Email Address: _____

Employer: _____ Years At Current Employer ___ Occupation: _____

Work Phone: () _____

Employer's Address: _____ City: _____ State: ___ Zip: _____

Preferred Method To Contact You: Home Phone Cell Phone Email Text

We confirm appointments by text and email unless you tell us otherwise.

PERSON RESPONSIBLE FOR ACCOUNT

Same as above (if yes, you can skip this section)

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

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

Phone: () _____ Work: () _____ Social Security #: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name: _____ Phone: () _____ Group/Policy #: _____

Insured's Name: _____ Birth Date: ___/___/___ Relation: _____

Insured's ID #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: () _____ Group/Policy #: _____

Insured's Name: _____ Birth Date: ___/___/___ Relation: _____

Insured's ID #: _____ Insured's Employer: _____

MEDICAL INSURANCE

Insurance Co. Name: _____ Phone: () _____ Group/Policy #: _____

Insured's Name: _____ Birth Date: ___/___/___ Relation: _____

Insured's ID #: _____ Insured's Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Phone: () _____ Work: () _____ Preferred Hospital: _____