LANCASTER SMILES

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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:_____