NEW PATIENT INFORMATION

☐ Call with sooner

Initial Contact

Date: _____ / _____ / _____ Appointment: _____ / _____ / _____ @ _____:_____

Taken by: _____ Referred By: _____

Patient's Name: _____ DOB: _____ / _____ / _____

Responsible Party / Parent Name: _____

Home #: _____ Wk #: _____ Cell #: _____

Home Address: _____

E - Mail Address: _____ Text OK : Yes □ No □

Reason for Visit: _____

_____

_____

Last Dental Visit: _____ Recent X-Rays: _____

Dental Insurance: Yes □ No □ Ins History Notes: _____

Insurance Subscriber Name: _____ DOB: _____ / _____ / _____

Insurance Carrier: _____

Employer Name: _____

SS / ID # ____ ____ ____ ____ ____ ____ ____ ____ ____ Group # _____

Taking Blood Thinners: Yes □ No □ PREMED Needed: Yes □ No □ Reason: _____

Reviewed the Insurance / Financial Office Policy: Yes □ No □ RX: _____

Quotes / Money / Ins Info: _____

_____

_____

Paperwork: Mailed □ (date:__/__/__) Complete at Office □ Will do by e-mail □ From Website □

MISC INFO / COMMENTS: _____

_____

_____