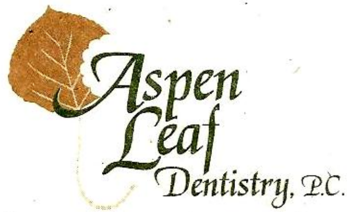

Dental Care For The Quality Conscious

NEW PATIENT INFORMATION

Name:____ Sex: M F
Last First Middle

Birthdate:________________ SSN:________________ Drivers Lic:________________

Marital Status: Single Married Separated Divorced Widowed

Home Address:______________________City:__________State:______ Zip:______

Home Phone#:________________ Work Phone #:________________ Cell Phone#:________________

Employer:________________Occupation:________________Employer Phone#:________________

Employer Address:________________________________

Spouse:________________________ Spouse's Employer:________________

Spouse's Work Phone#:________________________ Spouse's Cell Phone:________________

Name of closest relative not living with you: ________________________Phone #: ________________

Relation to patient:________________________

Emergency Contact Name:________________ Phone #1:________________ Phone #2:________________

Person Financially Responsible for Account:________________________________
Last First Middle

Birthdate:________________ SSN#:________________ Relation to Patient:________________

Address(if different):________________________ Phone #:________________

Responsible Person's Employer:________________________ Work Phone:________________

Responsible Person's Work Address:________________________________

Former Dentist:________________________ Address:________________________

Date of last dental visit:________________________

Physician:________________________ Address:________________________

Date of last physician visit:________________________

BEFORE YOU SIGN THIS FORM:
I am aware that, upon request, a copy of this office's NOTICE OF PRIVACY PRACTICES is available to me.

____
Signature

____
Date