SAMPLE

NEW PATIENT INFORMATION FORM

NAME (Last, First, MI)_____PREFERRED NAME_____

HOME ADDRESS_____
(street) (city) (state) (zip)

HOME PHONE_____WORK PHONE_____CELL NO._____

EMAIL ADDRESS_____

SS#_____-_____-_____ DATE OF BIRTH_____/_____/_____ SEX: M / F STATUS: S/ M/ D/ W

EMPLOYER NAME_____

EMERGENCY CONTACT & PHONE_____

RELATIONSHIP TO PATIENT_____

PLEASE CHECK WHICHEVER APPLY:

☐ PRIMARY DENTAL INSURANCE ONLY; SUBSCRIBER NAME_____
☐ PRIMARY DENTAL INSURANCE & SECONDARY DENTAL INSURANCE
☐ NO DENTAL INSURANCE AT THIS TIME

John Doe D.F.S., S.C.

I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT THE ABOVE INFORMATION IS GIVEN FOR THE PURPOSE OF OBTAINING CREDIT, AND I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, AS OF THE DATE OF THIS APPLICATION. I GIVE MY PERSONAL GUARTANTEE FOR ALL CHARGES INCURED.

SIGNATURE_____DATE_____

RESPONSIBLE (**if under 18 years of age**)
PARTY

_____
(Name) (Address) (SS#)