NEW PATIENT INFORMATION SHEET

NAME: ____

(Last) (First) (MI) (date of birth) (sex) (home phone)

HOME ADDRESS: ____

(Street) (Apt #) (City) (State) (Zip)

MAILING ADDRESS
(If different than above): ____

OCCUPATION: ____________________ **PLACE OF EMPLOYMENT:** ____________________
WORK PHONE: ____________________ **CELL PHONE:** ____________________
DENTAL INSURANCE CO.: ____________________ **PHONE:** ____________________
ADDRESS: ____________________ **GROUP#** ____________________

SOCIAL SECURITY NUMBER –OR- INSURANCE ID NUMBER: ____________________

REFERRED BY DOCTOR: ____

SPOUSE/PARENT
NAME: ____

(Last) (First) (MI) (date of birth) (sex) (home phone)

ADDRESS ____
(IF DIFFERENT FROM ABOVE)
OCCUPATION: ____________________ **PLACE OF EMPLOYMENT:** ____________________
WORK PHONE: ____________________ **CELL PHONE:** ____________________
DENTAL INSURANCE CO.: ____________________ **PHONE:** ____________________
ADDRESS: ____________________ **GROUP #** ____________________
SOCIAL SECURITY NUMBER –OR- INSURANCE ID NUMBER: ____________________

FINANCIAL CONSENT:

*If this office is able to accept your insurance company's assignment of benefits, your claim will be submitted after treatment is rendered. Please provide us the necessary information for your plan. The **estimated** co-payment amount provided by this office is considered **a guideline only** and is due at the time of service. This office can make no guarantee of insurance payment as estimated.*
"I understand that I am responsible for payment of services rendered and responsible for paying any charges my insurance does not cover. I am also responsible for any additional fees if this account is turned over for collection."

METHOD OF PAYMENT TODAY: __________ **SIGNATURE & DATE:** ____________________