



**New Patient Information**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ I prefer to be called: \_\_\_\_\_  Male  Female  
Last First Mi Mr Mrs Ms Dr

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Driver's License # \_\_\_\_\_

Home Address: \_\_\_\_\_  
Street City State Zip

Home Phone# \_\_\_\_\_ Work Phone# \_\_\_\_\_ Cell Phone# \_\_\_\_\_

How would you like your appointments confirmed:  Home  Work  Cell  E-mail Address: \_\_\_\_\_

Whom may we thank for referring you ? \_\_\_\_\_ Other family member seen by us: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long there? \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

Person to contact in case of an emergency: \_\_\_\_\_  
Name Phone#

**Neighbor or Relative not living with you**

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State

**Spouse Information**

His/Her Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Social Security# \_\_\_\_\_

Employer: \_\_\_\_\_ Work# \_\_\_\_\_ Driver's License# \_\_\_\_\_

**Insurance Information**

Primary Insurance Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Group#(Plan, Local, or Policy#): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip

Secondary Insurance Dental Coverage?  Yes  No Orthodontic Coverage?  Yes  No

Insurance Co. Name: \_\_\_\_\_ Phone#: (\_\_\_\_) \_\_\_\_\_ Group#(Plan, Local, or Policy#): \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_  
Street/PO Box City State Zip

Insured's Name: \_\_\_\_\_ Insured's Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Insured's Birthdate: \_\_\_/\_\_\_/\_\_\_ Relation: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Employer's Address: \_\_\_\_\_  
Street/PO Box City State Zip