NEW PATIENT INFORMATION

Name: (first)______________________________(last)____
S.S. Number: _______-_______-_______ Date of Birth: M______ D______ Y_________
Address: ______________________________City/State: ___________________Zip Code:__________
Email Address: ____
Home Phone: ________________ Work Phone:_________________ Cell Phone:_______________
Whom may we thank for telling you about our office?______________________________________

INSURANCE INFORMATION

Patient is: ☐ Subscriber ☐ Spouse ☐ Child ☐ Other dependant

Subscriber's Name: ____________________________SS # or Insurance ID #:___________________
Date of Birth: M_____ D_____ Y_______
Home Phone: ________________ Work Phone:_________________ Cell Phone:________________
Employer: _________________________________Group #: ____________________________________
Insurance Carrier: ____________________________________Insurance Phone: __________________
Insurance Address: _____________________City/State:_______________________ Zip Code:_______

When was your last dental visit? ____
Are you having any dental concerns at this time?____
Do you have any allergies or are you allergic to any medications?___________________________
Any existing medical conditions?____
Have you ever been told that you need to take antibiotics prior to dental visits? ☐ No ☐ Yes
If so, what for? ____
RX: ___________________ Pharmacy: ____________________ Pharmacy Phone: ________________

New patient exam:
Our new patient exam consists of taking necessary radiographs, performing a comprehensive exam, and informing you of any treatment you may need. ***If diagnosed with periodontal disease, a cleaning may NOT be done at this time.*

Emergency exam:
Our emergency exam consists of examining the problem area, taking the necessary radiographs, and informing you of what treatment is necessary. ***Treatment may not be done on the day of this visit.*

Cash, check or credit card accepted.
Financing available through Care Credit and Smart Care.