New Patient Information

Please take a minute to fill in all of the following information for our records:

Last Name:_____ First Name:_____
Title:_____ Middle Name :_____ Nickname:_____
Home Address:_____Apt. #:_____
Zip Code:_____City:_____County:_____State:_____
Home Phone:_____ Marital Status:_____ Sex:_____
Work Phone:_____ Employer:_____
Cell Phone:_____ Pager:_____
Social Security #: ____-____-____ Address:_____
Birth Date: ____/____/____ City:_____State:_____
Drivers License #_____ Zip Code:_____
Medical Alerts:_____
Referred By:_____

Dental Insurance ?: _____Yes _____No
If Yes, Name of Insurance Company_____
Group Number_____ Claims Address:_____
Are You Insured By Another Company? _____Yes_____No
If Yes, Name of Secondary Guarantor:_____
Social Security # for Secondary Guarantor _____-_____-_____
Secondary Guarantor's Employer:_____
Secondary Insurance Company_____
Group #:_____ Birthdate of Secondary Guarantor:_____

Signature of Person Responsible for Payment:_____

Person Responsible for Payment, If Different Than Above:
Name:_____
Address:_____
Signature:_____

Hobbies:_____
Clubs or Special Interests:_____
Nearest relative not living with you:
Name_____Phone #_____
Address_____City_____State____
Relatives in this practice:_____

Please be informed that any unpaid fees that require an outside collection agency will be subject to reasonable collection fee and/or attorney fees. Any insufficient funds checks returned by your bank will be subject to a $25.00 fee. I also understand that if my account goes over 120 days old I may be charged a Finance Charge of 1 ½% a month.