NEW PATIENT INFORMATION SHEET

Patient's Name: _____ Date of Birth: _____/_____/_____
(Please print)

Street Address**:** _____ Social Security #: _____-_____-_____

City, State, Zip: _____ Home Phone: (_____) _____-_____

E-Mail Address**:** _____Cell Phone: (_____) _____-_____

Sex: __ Female __ Male Marital Status: __ Married __ Single __ Divorced __ Separated __ Widowed

Name of Employer: _____Work Phone: (_____) _____-_____

Street Address, City, State, Zip: _____

STUDENT INFORMATION

Name of School: _____

((Please circle one): Part Time (Less than 12 units) - Full Time (More than 12 units)

Street Address, City, State, Zip: _____

EMERGENCY CONTACT

Name: _____ Phone #: (_____) _____-_____ Relationship: _____

GUARANTOR INFORMATION IF PATIENT IS A MINOR

Guarantor's Name: _____ Home Phone: (_____) _____-_____

Address: _____

Name of Employer: _____Work Phone: (_____) _____-_____

If the patient's parents are separated, with whom does the patient reside? Name: _____

_____

Primary General Dentist: _____

Physician: _____

Whom may we thank for referring you to our office? _____

Primary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____ /_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID#: _____

Group #: _____

Secondary Insurance

Name of Insurance: _____

Policy/Subscriber's Name: _____

Date of Birth: _____/_____ /_____

Social Security #: _____-_____-_____

Relationship to Patient: _____

ID#: _____

Group #: _____

Medical Insurance

Name of Insurance: _____

Policy/Sub's Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____ ___ Social Security#: _____-_____-_____

ID#: _____ Group#: _____

Patient *or* guarantor's signature: _____ **Date:** _____