Dental Health associates

Quality Care by Professionals Who Care

NEW PATIENT INFORMATION

Whom may we thank for referring you or how did you hear about us? _____

ABOUT YOU

[ ] Male [ ] Female

Name:_____I prefer to be called:_____

[ ] Single [ ] Married [ ] Child [ ] Other

Birth Date:___/___/_____ Age:_____ Social Security #:_____

Address:_____City:_____ State:____ Zip:_____

Home Phone: ( ) _____Cell Phone: ( ) _____Work Phone: ( ) _____

Employer:_____

Email Address:_____

Preferred Method To Contact You: [ ] Home Phone [ ] Cell Phone [ ] Email

PERSON RESPONSIBLE FOR ACCOUNT

[ ] Same as above (if yes, you can skip this section)

Name: _____ Birth Date:___/___/_____ Relation: _____

Billing Address: _____ City: _____State: ____ Zip: _____

Phone: ( ) _____ Work: ( ) _____ Social Security #: _____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insured's Name: _____ Birth Date: ___/___/_____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insured's Name: _____ Birth Date: ___/___/_____ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Phone: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Consent for Treatment

The information on these pages is true to the best of my knowledge. The undersigned hereby authorizes the doctor to take X-rays, study models, photographs, or other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental health needs. I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicted in connection with the patient, and further authorize and consent that doctor choose and employ such assistance as deemed fit.

SIGNED _____ DATE _____

Relationship to Patient: Self _____ Parent _____Guardian _____Trustee _____