



ESTHETIC AND
COMPREHENSIVE DENTISTRY

New Patient Form

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First Name: _____ Last Name: _____ Middle Initial: _____

Patient is: Policy Holder Responsible Party Preferred Name: _____

Responsible Party
(if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security: _____ Driver's License: _____

Responsible Party is also a Policy Holder Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ I would like to receive correspondence via email.

Birth Date: _____ Age: _____ Social Security: _____ Driver's License: _____

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

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Comments:

Primary Insurance
Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Social Security: _____

Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____ **Rem Deductible:** _____

Secondary Insurance
Information

Name of Insured: _____

Relationship to Insured: Self Spouse Child Other

Insured Social Security: _____

Insured Birth Date: _____

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Company: _____

Address: _____

City: _____ State: _____ Zip: _____

Rem. Benefits: _____ **Rem Deductible:** _____