NEW PATIENT FORM

PATIENT INFORMATION

PATIENT LAST NAME: _____ FIRST: _____ MI: ____

NICKNAME/PREFERED NAME: _____ MALE/FEMALE

D.O.B: _____ SOCIAL SECURITY#: _____ MARITAL STATUS: ____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE#: _____

EMPLOYER/ SCHOOL: _____ PHONE#: _____

CONTACT INFORMATION

PERSON RESPONSIBLE FOR ACCOUNT/FINANCES: _____

RELATIONSHIP TO PATIENT: _____ EMAIL: _____ @ _____

DO YOU AUTHORIZE OUR STAFF TO SEND YOU EMAIL CONFIRMATIONS, UPDATES, EVENTS, ETC? _____

HOME#: _____ CELL#: _____ WORK#: _____

EMERGENCY CONTACT: _____ PHONE#: _____

HOW DID YOU HEAR ABOUT ALSBURY DENTAL? _____

DENTAL INFORMATION

Have you ever been told you have periodontal disease? _____
If yes, have you had a Deep cleaning? _____
If yes, approximate date of cleaning _____

Are you interested in teeth whitening? _____
Is there anything you would like to change about your smile?
_____

I certify the above information to be correct to the best of my knowledge. I authorize the use of my signature on all insurance submissions. Alsbury Dental may use my health care information and may disclose such information to my insurance carrier for the purpose of obtaining payment for services. I authorize the assignment of all insurance benefits, if any, directly to Alsbury Dental. I understand that I am financially responsible for all charges whether or not reimbursed by my insurance carrier.

X _____