NEW PATIENT INFORMATION CHART: _____

The following confidential information is for our records only

A. PATIENT:_____

ADDRESS:_____CITY:_____ ZIP._____

BIRTH DATE:_____AGE_____ SEX_____

SOC. SEC. #:_____ DRIVERS LICENSE:_____

TELEPHONE: Day( )_____ Eve( )_____Email :_____

EMPLOYED BY: _____

ADDRESS:_____CITY:_____ ZIP._____

TELEPHONE:( ) _____ EXT:_____ HOW LONG: _____

OCCUPATION: _____

NO. YEARS AT PRESENT RESIDENCE: _____ OWN/RENT: _____

B. RESPONSIBLE PARTY OR SPOUSE.

NAME:_____

ADDRESS:_____CITY:_____ ZIP:_____

BIRTH DATE: _____ AGE:_____ SEX:_____

SOC. SEC. #: _____ DRIVERS LICENSE: _____

TELEPHONE: Day ( )_____ Eve( )_____Email :_____

EMPLOYED BY: _____

ADDRESS:_____CITY:_____ ZIP._____

TELEPHONE:( ) _____ EXT:_____ HOW LONG: _____

OCCUPATION: _____

C. DEPENDENTS:

NAME:_____

BIRTH DATE:_____ AGE_____ SEX_____

D. INSURANCE:

GROUP NAME: _____GROUP NO:_____

CERT.#:._____ID#:_____ UNION NAME:_____

INSURED:_____

E. HOW DID YOU HEAR ABOUT OUR OFFICE? (Please circle one)

Yellow Pages ( ) Sign on Bldg (SIG) ( ) Friends/Far (FF) ( ) Prepaid Health Plan (PP) ( )

Referred by:_____

F. IMPORTANT NOTICE (PLEASE READ)

To help you to determine your insurance coverage, we will prepare an estimate of the amount your insurance is likely to pay. This is only an estimate of what your insurance may pay toward the services. Any amount paid by your insurance in excess of the amount stated will be credited to your account or returned to you. Any amount less than that stated will be added to your account and billed to you.

We will assist you in every way to help you collect from your insurance company. However, you are personally responsible for the cost of all treatments received.

PLEASE SIGN THE FOLLOWING STATEMENT:

"I have read and understand the above notice and I agree that I am personally responsible for the cost of my dental care."

SIGNED: _____ **DATE:**_____