New Patient Information

Last Name _____

First Name _____

Preferred Name _____

DOB _____/_____/_____

SSN# _____-_____-_____

Home Address _____

City_____ **State** _____ **Zip** _____

Cell Phone _____

Home Phone _____

Work Phone _____

Email Address_____

Preferred Method of Contact: Cell ☐ **Home** ☐ **Work** ☐ **Email** ☐

Most Recent Dental Exam Date _____

Prior Dentist_____

How did you hear about our office?_____

Dental Insurance provider _____

Employer_____

Please complete the following if the primary insured is someone other than yourself

Name of primary insured _____

Employer _____

DOB_____/_____/_____ ***SSN*** _____-_____-_____

Reason for your appointment today (List dental concerns):

_____

_____

_____

_____