New Patient Information

Today's Date: _____

Name of Patient: _____

Patient's Date of Birth: _____

How did you hear about us?

☐ Friend ☐ Family Member ☐ General Dentist ☐ Other
☐ Magazine ☐ Newspaper

General Dentist: _____

Primary Physician: _____

Insurance Company: _____

(if Delta Dental which one?) _____

Phone #: _____

Insurance subscriber: _____

Member #: _____

Social Security #: _____-_____-_____

D.O.B.: _____/_____/_____

Permission to take photos: ☐ Yes ☐ No _____

X-rays: ☐ Yes ☐ No _____

Permission to use photos and testimonials: ☐ Yes ☐ No _____