Welcome! Please tell us about yourself…..

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

Preferred Name: _____ Birthdate: _____ Sex: __ Male __ Female

Marital Status: __ Married __ Single __ Divorced __ Separated __ Widowed Student Status: __ Full time __ Part time

Cell phone # : _____ I would like to receive correspondence via text: __ yes __ no

Email address: _____ I would like to receive correspondence via email: __ yes __ no

Home Phone # : _____ Soc. Sec # : _____ Drivers Lic. # _____

Home Address: _____

City, State, Zip: _____

Employer: _____ Work Phone # : _____ __ Full time __ Part time __ Retired

How did you hear about New Image Dentistry? ( ) Facebook, ( ) Internet Search, ( ) Advertisement (please specify type) _____

( ) Friend / Family (name)_____ ( ) Referred by another doctor (name) _____

Do you have a preferred Dentist? _____ Hygienist? _____

Do you have a preferred Pharmacy? _____ Tel # : _____

Parent or Guardian of Patient listed above (if minor):_____

Address if different: _____

Cell phone # :_____ I would like to receive correspondence via text: __ yes __ no

Email address: _____ I would like to receive correspondence via email: __ yes __ no

Home Phone # : _____ Soc. Sec # : _____ Drivers Lic. # _____

Employer: _____ Work Phone # : _____

Primary Insurance Information:

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse __ Child __ Other

Insured ID or Soc. Sec. # _____ Medicaid ID: _____ Insured Birthdate: _____

Employer Name: _____ Insurance Company: _____

Please provide a copy of Insurance card to the front desk staff.

Secondary Insurance Information:

Name of Insured: _____ Relationship to Insured: __ Self __ Spouse __ Child __ Other

Insured ID or Soc. Sec. # _____ Medicaid ID: _____ Insured Birthdate: _____

Employer Name: _____ Insurance Company: _____

Please provide a copy of Insurance card to the front desk staff.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of Patient (Parent or Guardian if minor):

_____ Date : _____