

New Patient Form

INFORMATION REQUIRED FOR CASE HISTORY RECORD

PATIENT INFORMATION

First Name *

Last Name *

Middle Name

Social Security Number

Mailing Address *

City *

State *

Zip *

Phone

Cell *

Birthdate *

mm/dd/yyyy

Gender *

Student? *

No Yes

Marital Status *

Single

Married

Separated / Divorced

Widowed

Work Name

Work Address

Work City

Work State

Work Zip

Work Phone

Extension

Referring Dentist *

Name of MD *

General Dentist *

Preferred Pharmacy *

INSURANCE INFORMATION

Do you have dental insurance? *

No Yes

Do you have secondary dental insurance or medical insurance? *

No Yes

FINANCIAL RESPONSIBILITY

Who will be financially responsible for the account? *

Patient

Patient's Spouse

Patient's Parent

Other (describe)

First Name *

Last Name *

Middle Name

Social Security Number

Mailing Address *

City *

State *

Zip *

Phone

Cell *

Work Name

Work Address

Work City

Work State

Work Zip

Work Phone

Extension

Birthdate *

mm/dd/yyyy

FINANCIAL AGREEMENT

I understand and agree that the fee for services is due at the time of treatment, and if I have dental insurance any co-payment for treatment will be made at the time of treatment and I will be responsible for any charges not paid by my insurance. I will also be responsible for any costs of collection or attorneys' fees in the event they are necessary. I hereby assign all medical and/or surgical benefits to which I am entitled including private insurance and any other health plan to Dr. Valentine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature of Person Financially Responsible *

Sign here

Next