PATIENT INFORMATION

Please Print

DATE ____________________________________

PATIENT'S NAME	
STREET ADDRESS	
CITY, STATE, ZIP	
MAILING ADDRESS	
E-MAIL ADDRESS	
PRIMARY PHONE	☐ H ☐ W ☐ C
SECONDARY PHONE EXTENSION	☐ H ☐ W ☐ C
DATE OF BIRTH	SEX M F
MARITAL STATUS	M S D W
PATIENT'S SOCIAL SECURITY NO.	
PARENT / RESPONSIBLE PERSON	
PARENT'S SOCIAL SECURITY NO.	

IS THIS PATIENT EMPLOYED?	YES NO
NAME OF EMPLOYER	
EMPLOYER'S ADDRESS	
IS THE PATIENT A FULL-TIME STUDENT?	YES NO
NAME OF SCHOOL	
DOES THIS PATIENT HAVE DENTAL INSURANCE?	YES NO
(IF SO, PLEASE COMPLETE INSURANCE INFORMATION BELOW)	

WHO IS FINANCIALLY RESPONSIBLE FOR THIS DENTAL BILL?

THIS PERSON'S RELATIONSHIP TO THE PATIENT IS

TODAY I WILL BE PAYING BY
☐ CASH ☐ VISA / MASTERCARD ☐ CARE CREDIT

HOW DID YOU HEAR ABOUT OUR PRACTICE? (Please check one)	
DR'S PREVIOUS PATIENT (9000070)	INSURANCE CO. WEBSITE (9000080)
DENTISTS OF NEWTOWN WEBSITE (9000220)	DRIVING / WALKING BY OFFICE (9000010)
SOCIAL MEDIA (NAME) (9000020)	GOOGLE SEARCH (9000210)
MAILER – RESIDENT LETTER (9000030)	
MAILER – POSTCARD (9000090)	
REFERRED BY CURRENT EMPLOYEE (9000060)	
OUTSIDE REFERRAL (9000000) FROM DOCTOR ______________________	
REFERRED BY FRIEND / FAMILY (9000040 / 50)	
NAME OF REFERRING PERSON	
ADDRESS OF REFERRING PERSON	

FOR OFFICE USE ONLY

Acct. # ____________________ Provider # ____________________
IE #109 Emer #110 Ortho #113 Previous Pt. #114

DENTAL INSURANCE INFORMATION (If applicable)

PRIMARY INSURANCE CO.	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NUMBER
NAME OF INSURED	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO. OF INSURED	
INSURED'S EMPLOYER	INSURED'S DATE OF BIRTH	GROUP NUMBER	I.D. NUMBER
SECONDARY INSURANCE CO.	ADDRESS (STREET, CITY, STATE, ZIP)		PHONE NUMBER
NAME OF INSURED	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO. OF INSURED	
INSURED'S EMPLOYER	INSURED'S DATE OF BIRTH	GROUP NUMBER	I.D. NUMBER

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the information and have completed the above form. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Signature ____________________________________ Date

The doctors and staff will greatly appreciate your courtesy in keeping all appointments promptly.

A fee will be charged to your account for failed appointments or cancellations with less than 24 hours notice.