ASSOCIATES IN DENTISTRY

Healthy Smiles For All Ages

NEW PATIENT INFORMATION

HAS ANY ONE IN THE FAMILY BEEN A PATIENT HERE BEFORE? ❑ YES ❑ NO

IF YES, NAME _____

DATE: _____ / _____ / _____ ACCOUNT #: _____

ADULT PATIENT NAME: _____

CHILD PATIENT NAME: _____

NAME YOU LIKE TO BE CALLED: _____

PARENTS NAME: _____

ADDRESS: _____ CITY/ZIPCODE: _____

HOME PHONE: _____ WORK: _____ CELL: _____

EMAIL ADDRESS: _____

HOW CAN WE BEST REACH YOUR FOR APPOINTMENT CONFIRMATION? _____

PRIMARY DENTAL INSURANCE: _____

INSURED'S NAME: _____ DOB: _____

INSURED'S SS#: _____ EMPLOYER: _____

IS THERE SECONDARY COVERAGE: _____

INSURED'S NAME: _____ DOB: _____

INSURED'S SS#: _____ EMPLOYER: _____

IN CASE OF AN EMERGENCY CONTACT: _____

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NEW PATIENT QUESTIONNAIRE

HOW DID YOU LEARN OF OUR OFFICE?

❑ Friend or Relative: _____

Name and Address: _____

❑ Internet: _____

❑ Yellow Pages: _____

❑ Newspaper: _____

❑ Radio/TV: _____

❑ Employee of ADL: _____

Name: _____

WHY DID YOU CHOOSE OUR DENTAL OFFICE?

❑ Hours: _____

❑ Convenient Location: _____

❑ Group Practice: _____

❑ Recommended by person above: _____

❑ Desired Specific Doctor: _____

❑ Recommended by another Dentist: _____

Name: _____

WHY DO YOU NEED TO SEE A DENTIST AT THIS TIME?

❑ Immediate problem

❑ Insurance coverage in effect now

❑ Concerned with general oral health

❑ School exam required

❑ Second opinion