

NEW PATIENT INFO

DATE: _____
NO: _____

— PATIENT INFORMATION —

LAST NAME _____ FIRST NAME _____ NICKNAME _____ GENDER _____
 SSN _____ BIRTHDATE _____ AGE _____ EMAIL _____
 ADDRESS _____ CITY _____ STATE _____ ZIP _____
 CELL # _____ HOME # _____ WORK # _____ FAX # _____

| | | |
|------------------------|--------------------------|---|
| <i>(IF APPLICABLE)</i> | SCHOOL _____ GRADE _____ | NAME OF DENTIST _____ DATE OF LAST VISIT _____ |
| | [] SINGLE [] MARRIED | ANY PATIENTS IN THE FAMILY? PLEASE LIST _____ |
| | [] DIVORCED [] WIDOWED | _____ |
| | OCCUPATION _____ | ANY OTHER CHILDREN IN THE HOUSE? PLEASE LIST WITH AGE _____ |
| EMPLOYER _____ | _____ | _____ |

— GUARDIAN & INSURANCE INFORMATION —

FATHER'S NAME _____ **SSN** ____ - ____ - ____ **DOB** ____ / ____ / ____
ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** ____
CELL # _____ **HOME #** _____ **CELL PHONE CARRIER** _____
OCCUPATION/EMPLOYER _____ **EMAIL** _____

MOTHER'S NAME _____ **SSN** ____ - ____ - ____ **DOB** ____ / ____ / ____
ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** ____
CELL # _____ **HOME #** _____ **CELL PHONE CARRIER** _____
OCCUPATION/EMPLOYER _____ **EMAIL** _____

GUARDIAN'S NAME _____ **SSN** ____ - ____ - ____ **DOB** ____ / ____ / ____
ADDRESS _____ **CITY** _____ **STATE** ____ **ZIP** ____
CELL # _____ **HOME #** _____ **CELL PHONE CARRIER** _____

PERSON RESPONSIBLE: FATHER MOTHER GUARDIAN

NAME _____ RELATION TO PATIENT _____
 INSURANCE _____ CONTRACT # _____
 GROUP MEMBER BIRTHDATE _____ GROUP # _____

(IF DIVORCED) CUSTODIAL PARENT?

 MAY INFORMATION BE RELEASED TO
 NONCUSTODIAL PARENT? [Y] [N]