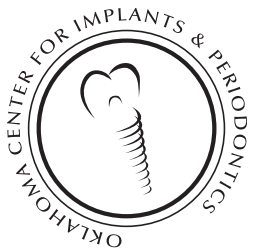

NEW PATIENT INFORMATION

(Please fill out paperwork completely)

Name: _____ Referring Doctor: _____

Address: _____ City _____ State _____ Zip _____

SSN: _____ Employer: _____ Work # _____

Date of Birth: _____ Age: _____ Home Phone# _____ Cell # _____

Email Address: _____

SPOUSE or (If Minor) PARENT or LEGAL GUARDIAN information:

Name _____ SS # _____

Date of Birth _____ Employer _____ Position _____ Phone # _____

PERSON TO NOTIFY IN THE EVENT OF AN EMERGENCY: (Other than above) Phone# _____ Cell # _____

Name _____ Relationship to patient _____

DENTAL PRIMARY INSURANCE: _____

Address: _____

Phone: _____

Policy Holder _____ Relationship to Patient: _____

Policy Number _____ ID # _____ Group # _____

Date of Birth: _____ SS # _____ Employer _____

DENTAL SECONDARY INSURANCE: _____

Address: _____

Phone: _____

Policy Holder _____ Relationship to Patient: _____

Policy Number _____ ID # _____ Group # _____

Date of Birth: _____ SS # _____ Employer _____

I fully agree and understand that payment is due at the time of service. 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 hereby authorize release of information for insurance claim purposes. Financial arrangements, if needed, should be made prior to treatment.

Date _____

Patient, Parent, or Legal Guardian's Signature

Robin Henderson, DMD, MS Chris Poore, DDS, MS Tracey Whitley, DMD, MS
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