NW DENTAL
NEW PATIENT FORM

Today's Date:___/___/___

Referred to us by_____

Appointment Concerns: _____

Patient name _____ **Birthday** _____/_____/_____

SS# _____-_____- _____ **Driver's License #**_____

Address _____ **City** _____ **ST** ____ **Zip** _____

Email _____

Phone: Home _____ **Cell** _____

Spouse/Guardian Name: _____ **Contact:** _____

Emergency Contact: _____ **Contact:**_____

INSURANCE: YES NO ***Patient must call insurance if ANY info not present***

Policy Holder _____or [ ] SELF DOB_____/_____/_____

Relationship to patient: Spouse Child Dependent

Insurance Co. Name_____ Ins. Co. Phone#_____

ID# or SS#_____ GROUP#_____

Employer _____

Address where to send claims: _____

Additional family members:
_____DOB_____
_____DOB_____

Last Dental Visit_____ **What services did you have done** _____

Previous Dentist _____ **Last Radiographs**_____

Phone number _____ **OR Email** _____

Any medical alerts that we should be aware of? _____