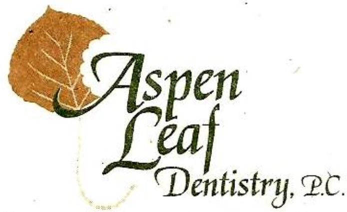

Dental Care For The Quality Conscious

NEW PATIENT INFORMATION

Name:____ Sex: M F
Last First Middle

Birthdate:__________________ SSN:__________________ Drivers Lic:__________________

Marital Status: Single Married Separated Divorced Widowed

Home Address:__________________City:__________________State:________ Zip:__________

Home Phone#:__________________ Work Phone #:__________________ Cell Phone#:__________________

Employer:__________________Occupation:__________________Employer Phone#:__________________

Employer Address:____

Spouse:__________________ Spouse's Employer:__________________

Spouse's Work Phone#:__________________ Spouse's Cell Phone:__________________

Name of closest relative not living with you: __________________Phone #: __________________

Relation to patient:__________________

Emergency Contact Name:__________________ Phone #1:__________________ Phone #2:__________________

Person Financially Responsible for Account:____
Last First Middle

Birthdate:__________________ SSN#:__________________ Relation to Patient:__________________

Address(if different):__________________ Phone #:__________________

Responsible Person's Employer:__________________ Work Phone:__________________

Responsible Person's Work Address:____

Former Dentist:__________________ Address:__________________

Date of last dental visit:__________________

Physician:__________________ Address:__________________

Date of last physician visit:__________________

BEFORE YOU SIGN THIS FORM:
I am aware that, upon request, a copy of this office's NOTICE OF PRIVACY PRACTICES is available to me.

____
Signature

____
Date

1190 West Ash Street, Ste. B Windsor, Colorado 80550 Ph. (970) 674-0250