Aspen Leaf DENTISTRY, P.C.
Dental Care for The Quality Conscious

New Patient Information

Name:_____ Sex: M F
Last First Middle

Birthdate:_____SSN:_____Email:_____

Marital Status: Single Married Separated Divorced Widowed

Home address:_____City:_____State:_____Zip:_____

Home phone #:_____Work phone #:_____Cell #:_____

Employer:_____Occupation:_____Employer phone #:_____

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 #:_____

Person financially responsible for account:_____

Birthdate:_____SSN:_____Relation to patient:_____

Address (if different):_____Phone #:_____

Responsible person's employer:_____Work phone #:_____

Former dentist_____Date of last dental visit:_____

Physician:_____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 CO 80550 PH. (970) 674.0250