

Date: _____

Appointment Time: _____

Appointment Date: _____

Doctor: _____

NEW PATIENT INFORMATION SHEET

Patient Name: _____, _____
Last Name *First Name*

DOB: _____

S.S. #: _____

Parent Name (if Minor): _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____ Alternate Phone Number: _____

Email: _____

DENTAL INSURANCE INFORMATION

- | | | |
|---|--|--|
| <input type="checkbox"/> DeltaCare USA | <input type="checkbox"/> Delta Dental of _____ (State) | <input type="checkbox"/> Comp Benefits PPO |
| <input type="checkbox"/> Delta Dental Base Plan | <input type="checkbox"/> PPO | <input type="checkbox"/> MetLife PPO |
| <input type="checkbox"/> Delta Dental Buy-up Plan | <input type="checkbox"/> Humana PPO | |

Subscriber/Policy Holder: _____ Policy Holder's DOB: _____

Subscriber ID#: _____

Group #: _____

For Office Use Only

Effective Date: _____

Verified by: _____ Date: _____