Penniall
family dental

NEW PATIENT FORMS

*Please complete all **4 pages** to the best of your ability.*

PATIENT INFORMATION FORM	**Today's Date**
Patient Name*: First Last	I prefer to be called
Address*: Street City	State Zip
Phone #*: Cell Home	**Preferred contact method*:**
Email*:	▢ Home Phone ▢ Cell Phone ▢ Email
Date of Birth*: **Sex*:** ▢ Male ▢ Female	**Marital Status:**
Employment Status: ▢ Full Time ▢ Part Time ▢ Retired ▢ Student ▢ Unemployed	**Occupation:**
In case of emergency, who should be notified?*	
Relationship to Patient*:	**Phone Number*:**
Do you have dental insurance?* ▢ Yes ▢ No ▢ Unsure ▢ Other *(explain)*	

RESPONSIBLE PARTY INFORMATION		
Name: First Last		**Date of Birth:**
Phone #:	**Relationship to Patient:** ▢ Self ▢ Spouse ▢ Parent ▢ Other *(explain)*	
Address: Street City	State	Zip
Social Security #:	**Drivers License #:**	**State:**

INSURANCE INFORMATION	
Employee Name: First Last	
Employer Name:	
Insurance Company:	
Group #:	**Member ID:**

HOW DID YOU HEAR ABOUT US?*
▢ Search Engine (Google, etc.) ▢ Facebook ▢ Insurance ▢ Driving By ▢ Word of Mouth ▢ Other *(explain)*
Is there someone we may thank for referring you to our office?

I give permission for the doctor or authorized staff to use x-rays, study models, and other diagnostic tools for a thorough assessment of (patient name) _____ and authorize recommended treatment, assistance, and use of anesthesia, sedation, and medication as needed. I understand the risks of anesthesia and have the right to ask for an explanation of potential complications.

Signature of Patient or Responsible Party _____ Date _____