Tammy I. Artis
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IMPLANT AND GENERAL DENTISTRY

New Patient Form

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First Name: Last Name: Middle Initial:

Patient is: ❍ Policy Holder ❍ Responsible Party Preferred Name:

Whom May We Thank For Referring You?

Responsible Party
(if someone other than the patient)

First Name: Last Name: Middle Initial:

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Birth Date: Social Security:

❍ Primary Insurance Policy Holder ❍ Secondary Insurance Policy Holder

Patient Information

Address:

City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email Address: ❍ I would like to receive correspondence via email.

Birth Date: Age: Social Security:

Sex: ❍ Male ❍ Female Marital Status: ❍ Single ❍ Married ❍ Separated ❍ Divorced ❍ Widowed

Employment Status: ❍ Full Time ❍ Part Time ❍ Retired ❍ Student

Comments:

Primary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip:

Secondary Insurance Information

Name of Insured:

Relationship to Insured: ❍ Self ❍ Spouse ❍ Child ❍ Other

Insured Social Security:

Insured Birth Date:

Employer:

Address:

City: State: Zip:

Insurance Company:

Address:

City: State: Zip: