Emerald
DENTAL STUDIO

New Patient Information Form

Date:_____

Last Name:_____ First Name:_____ Birth Date:_____

Preferred Name:_____ SSN:_____ Zip Code:_____

Street Address:_____ City:_____ State:_____

Email:_____ Cell Phone:_____
Preferred contact method: _ Email _Cell Phone

Employer:_____ Occupation:_____ Work City:_____

Gender: __Male __Female __Other

Student Status: __Non-Student __Student Name of School:_____

Emergency Contact Person:_____ Phone:_____
Relationship:_____

Is the patient a minor? __No __Yes

Name of Parent/Legal Guardian:_____
Parent/Guardian Phone:_____

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Dental Insurance Information

Primary Insurance Company: _____

Insurance Company Phone:_____

Patient Subscriber ID number:_____ Group Number:_____

Is the patient a dependent on another person's plan? __Yes __No

(If patient is a dependent) Name of primary Subscriber:_____

Primary Subscriber Birth Date:_____

Patient relationship to primary insurance holder:_____

Primary Subscriber ID or SSN:_____

Secondary Insurance Company: _____

Insurance Company Phone:_____

Patient Subscriber ID number:_____ Group Number:_____

Is the patient a dependent on another person's plan? __Yes __No

(If patient is a dependent) Name of primary Subscriber:_____

Primary Subscriber Birth Date:_____

Patient relationship to primary insurance holder:_____

Primary Subscriber ID or SSN:_____

How did you hear about our office?_____

Date:_____

Signature:_____