1800 S. Independence Pkwy Suite 100, McKinney, TX 75070
Tel: 214-592-9090 Fax: 214-592-9095

New Patient Form

PATIENT INFORMATION

Name ____ Preferred Name:__________________________

❑Married ❑ Single ❑ Minor ❑ Male ❑Female DOB ___________ SS #________________

Home Phone __________________ Cell _____________________ Best Time to Call :_______________

Email___________________________ Preferred Appointment Time: Morning, Afternoon, M T W TH F S

Home/ Mailing Address____

Employer Name _____________________ Occupation______________ Work Phone _______________

Work Address:____

If Full-time Student, School Name ____

Emergency Contact Name (nearest but not leaving with you)_____________________________________
Phone:______________________________ Relationship to Patient _________________________

Please Circle One: Self Pay or Insurance

REFERRAL INFORMATION

Whom may we thank for referring you to our office? ❑Another patient, friend ❑ Newspaper ❑ Postcard ❑ Other_______________ Name of person referring you to our practice _____________________________

INSURANCE INFORMATION

Primary Subscriber Name:____________________________________ Is subscriber a patient? ❑Yes ❑ No

Insurance Company: ________________________ Insurance Plan Type/Name________________________

Subscriber DOB ____________________ SS # ____________________ ID#________________________

Group #___________________ Insured's Employer Name________________ Employer Phone__________

Insured's Address:____

Patient's relationship to primary subscriber ❑Self ❑Spouse ❑Child ❑Other __________

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or credit information. I understand the total balance for all services is my responsibility. I authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's or Guardian's Signature____Date ____________