EDGEVIEW DENTAL

New Patient Information

FIRST NAME	MIDDLE	LAST NAME	NICKNAME
SSN	DOB	HOME ADDRESS	ZIP CODE
HOME PHONE	WORK PHONE	CELL PHONE	SEX M☐ F☐
EMAIL	MARITAL STATUS		OCCUPATION
REF. DOCTOR	REF. PATIENT	STUDENT STATUS/ SCHOOL ATTENDING	

Primary Dental Insurance Coverage

SUBSCRIBER NAME	SSN	DOB
ADDRESS	RELATION TO PATIENT	
EMPLOYER	ADDRESS	
PLAN NAME	GROUP NUMBER	
INSURANCE COMPANY	ADDRESS	

Secondary Dental Insurance Coverage

SUBSCRIBER NAME	SSN	DOB
ADDRESS	RELATION TO PATIENT	
EMPLOYER	ADDRESS	
PLAN NAME	GROUP NUMBER	
INSURANCE COMPANY	ADDRESS	

Medical Insurance Coverage

SUBSCRIBER NAME	RELATION TO PATIENT
ADDRESS	PLAN NAME

FINANCIALLY RESPONSIBLE PARTY

NAME AND ADDRESS	
SIGNATURE	DATE

Emergency Contact Information

NAME	RELATION TO PATIENT	CONTACT PHONE

Which family member may we share dental information with?

NAME _____ RELATION TO PATIENT _____

AUTHORIZATION AND RELEASE

The information I've provided is accurate and complete to the best of my knowledge. I will not hold my dentist of any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

SIGNATURE _____ DATE _____