PATIENT INFORMATION

PATIENT NAME: ____

Please complete the following information (please print clearly):

Pt is an Adult ☐ Child ☐ Guardian's Name: ____

Client information & health history completed by: _____________________________ Date: _____________

Relationship to Patient: ____________________________________ Phone # ___________________________

Email address: ____

Patient Name: _______________________________________ Date of Birth: __________________ Age: _______

Address: ____

Street # Street Name Unit # City Postal Code

Long term care or hospital facility: _____________________________________ Room #: ____________________

Last dental visit: ______________________________ Last dental hygiene visit: _____________________________

Dentist's Name: ____ Phone: _______________________________

Do you have a hip/knee or joint replacement, or require antibiotics prior to dental cleanings for any other reason? _______

Who referred you to Preferred Dental Hygiene Services? ____

Do you have dental insurance: ☐ Yes ☐ No

If YES – Policy Holder Name: ____ Date of Birth: _____________________

Relationship to patient: __________________ Insurance Company: ______________________________________

Policy /Group # ___________________________ I.D. or certificate # _______________________________________

Person responsible for payment of account: _______________________________ Relationship: _________________

Phone # Home: ____________________ Work: ______________________ Cell: ________________________

Employer: ____ Payment preference: VISA ☐ MC ☐

Best time for appointments: ☐ Morning ☐ Afternoon ☐ Either

Primary Contact Person: ____ Relationship__________________

Address: ____

Phone #: Home: __________________ Work: _______________________ Cell: __________________________

Second Contact Person: __________________________________ Relationship____________________________

Phone #: Home: __________________ Work: _______________________ Cell: __________________________

Signed: _______________________________ Print Name: ____________________________ Date: ______________

ACCOUNTS ARE DUE WHEN SERVICES ARE RENDERED. FOR YOUR CONVENIENCE PAYMENT MAY BE MADE BY VISA OR MC OVER THE PHONE

For Office Use

Appointment booked: Provider: _________________________ Date: _________________ Time: ___________

NEW PATIENT INFORMATION FORM