STONEHENGE
FAMILY & COSMETIC DENTISTRY

NEW PATIENT INFORMATION FORM

PATIENT NAME: _____ , _____ , _____ DATE: _____
Last Name First Name M.I.

SOCIAL SECURITY #: _____ - _____ - _____ DOB: _____ AGE: _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ DIVORCED ☐ WIDOWED

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: (_____) -_____ - _____ WORK PHONE: (_____) - _____ - _____ Extension _____

CELL PHONE: (_____) -_____ - _____ MAY WE SEND YOU TEXT MESSAGES?: ☐ YES ☐ NO

EMAIL: _____ WOULD YOU LIKE TO CONFIRM YOUR APPOINTMENTS BY EMAIL?: ☐ YES ☐ NO

HOW DID YOU HEAR ABOUT US?: ☐ CURRENT PATIENT (Patient's Name:_____) ☐ WEBSITE ☐ GOOGLE

☐ SOCIAL MEDIA ☐ PHONEBOOK ☐ PRINTED AD ☐ ELON UNIVERSITY ATHLETICS ☐ OTHER (Source:_____)

PATIENT EMPLOYER / SCHOOL: _____ OCCUPATION: _____

EMPLOYER / SCHOOL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER PHONE: (_____) -_____ - _____

EMERGENCY CONTACT: NAME: _____ RELATIONSHIP: _____ PHONE: (_____) -_____ - _____

PRIMARY DENTAL INSURANCE INFORMATION

CARDHOLDER NAME: _____ , _____ , _____
Last Name First Name M.I.

SOCIAL SECURITY #: _____ - ____ - _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS (ONLY if different from the patient): _____

CITY: _____ STATE: _____ ZIP CODE: _____

DENTAL INSURANCE COMPANY / CARRIER: _____ MEMBER / SUBSCRIBER ID #: _____

CARDHOLDER EMPLOYER: _____ GROUP / PLAN #: _____

DENTAL INSURANCE CUSTOMER SERVICE PHONE NUMBER: (_____) -_____ - _____

ADDITIONAL / SECONDARY DENTAL INSURANCE INFORMATION

IS THE PATIENT COVERED BY ANY ADDITIONAL or SECONDARY DENTAL INSURANCE?: ☐ YES ☐ NO (If YES, please provide info. below)

CARDHOLDER NAME: _____ , _____ , _____
Last Name First Name M.I.

SOCIAL SECURITY #: _____ - ____ - _____ DOB: _____ RELATIONSHIP TO PATIENT: _____

ADDRESS (ONLY if different from the patient): _____

CITY: _____ STATE: _____ ZIP CODE: _____

DENTAL INSURANCE COMPANY / CARRIER: _____ MEMBER / SUBSCRIBER ID #: _____

CARDHOLDER EMPLOYER: _____ GROUP / PLAN #: _____

DENTAL INSURANCE CUSTOMER SERVICE PHONE NUMBER: (_____) -_____ - _____