ATLANTIS DENTAL

FAMILY & COSMETIC DENTISTRY

NEW PATIENT INFORMATION FORM

Name: ______________________________ Date: ______________

Address: ______________________________ City: ______________

Prov.: ______ Postal code: ____________ Home phone: ______________ Work phone: ______________

Cell phone: ______________ Email: ______________ *Opt in Newsletter: Yes No

Date of birth: ______________ Sex: ______ If child, parent's name: ______________

Person to contact in case of emergency: ______________________________

Relationship to Patient: ______________ Phone: ______________

If student, name of school: ______________________________ Grade: ____________

Whom may we thank for referring you: ______________________________

DL#: ______________ SI#: ______________

Responsible Party *(Please complete all information if different from above)*

Name: ______________________________ Relationship to patient: ______________

Address: ______________________________ City: ______________

Home phone: ______________Date of Birth: ______________ Work phone: ______________

Cell phone: ______________

Is this person currently a patient in our office? YES NO

Insurance Information

Name of insured: ______________________________ Date of Birth: ______________

Insurance company: ______________________________

Insurance year end: __________ Group/individual policy #: ______________ ID / Certificate #: ______________

Annual maximum: $____________ Annual deductible: $____________

Percentage coverage: Basic: __________% Major: __________% Ortho: __________%

Recall frequency: __________ Polish/fluoride frequency: ________ Scaling/root planing limit: $________ #units: ________

Do you have additional insurance? YES NO **If yes, complete the following:**

Name of insured: ______________________________ Date of Birth: ______________

Insurance company: ______________________________

Insurance year end: __________ Group/individual policy #: ______________ ID / Certificate #: ______________

Annual maximum: $____________ Annual deductible: $____________

Percentage coverage: Basic: __________% Major: __________% Ortho: __________%

Recall frequency: __________ Polish/fluoride frequency: ________ Scaling/root planing limit: $________ #units: ________

Signature of patient or parent if minor. ______________________________

*By opting in to our patient newsletter you will receive monthly updates from our office. You may also receive periodical email updates informing you of our specials and promotions. You will be able to unsubscribe at any time.