Sugar Hill Family Dental

New Patient Information

Patient Name: _____
Last First MI Preferred name

☐Male ☐Female ☐ Married ☐Single ☐ Child

☐Other_____

Social Security #: _____ **Birth Date:**_____

Phone (Home): _____ **(Work):** _____ Ext: _____ **(Cell):**_____

Email address: _____

Address: _____
Street

_____
City State Zip Code

Spouse or Account Holder Information

The following is for: the patient's spouse the person responsible for payment

Name: _____ **Birth Date:** _____**Social Security #:** _____

☐Male ☐Female ☐ Married ☐Single ☐ Child ☐Other_____

Phone (Home): _____ **(Work):** _____ **(Cell):** _____

Address: _____
Street City State Zip Code

Employer name:_____

Address:_____

Employment Information

Patient

Employer Name:_____ Occupation:_____

Address:_____
Street City State Zip Code

Insurance Information

Primary Insurance

Insurance Plan Name: _____ Phone:_____

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Social Security/ID #: _____ Group #:_____

Insured's Address:_____
Street City State Zip Code

Insured's Employer Name: _____

Address:_____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other_____

We always appreciate referrals! Please tell us how you heard about us.

_____

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