

CAHOON FAMILY DENTAL

New Patient Information Sheet

Section A. Patient Information

Name _____
Address _____
Employer _____
Email _____
Age _____ Sex _____ Marital Status _____

Today's Date _____
Date of Birth _____
Social Security # _____
Driver's License # _____
Home Phone # _____
Work Phone # _____
Cell Phone # _____

How did you hear about Cahoon Family Dental? _____

Section B. Emergency Contact

Name _____
Home Phone # _____
Cell Phone # _____

Relationship to Patient _____
Work Phone # _____

Section C. Responsible Financial Party Information

Is the Responsible Party the same as the Patient listed in Section A. above? Yes No

If different, please enter the information for the Responsible Party below.

Name _____
Address _____
Email _____
Work Phone # _____

Relationship to Patient _____
Social Security # _____
Driver's License # _____
Home Phone # _____
Cell Phone # _____

Section D. Primary Insurance Information

Insured Name _____
Home Address _____
Employer _____
Work Address _____
Insurance Co. _____
Ins Address _____

Relationship to Patient _____
Date of Birth _____
Social Security # _____
Driver's License # _____
Home Phone # _____
Work Phone # _____
Group # _____
Member ID # _____
Ins Phone # _____

Section E. Secondary Insurance Information

Insured Name _____
Home Address _____
Employer _____
Work Address _____
Insurance Co. _____
Ins Address _____

Relationship to Patient _____
Date of Birth _____
Social Security # _____
Driver's License # _____
Home Phone # _____
Work Phone # _____
Group # _____
Member ID # _____
Ins Phone # _____