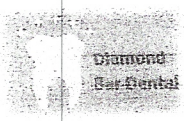

New Patient Form

PATIENT INFORMATION

Name_____ Birth Date_____ Social Security # _____
Address_____ City_____ State _____ Zip Code _____
E-mail _____ Cell Phone(___)_____Home Phone(___)_____
Sex ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Minor
Employer name _____ Employer Phone (___)_____
Spouse or Parents Name_____ Cell Phone(___)_____Work Phone(___)_____
Person to contact in case of emergency _____ Phone(___)_____
Whom may we thank for referring you? _____

RESPONSIBLE PARTY

Name of responsible party_____ Relationship to patient_____
Social Security # _____ Birth Date _____ Phone (___)_____
Employer _____ Work Phone (___)_____

Insurance Information

Subscriber Name _____Relationship to patient _____ Birth Date _____
Social Security #_____ Date Employed _____
Insurance Name _____ Insurance ID #_____ Group ID #_____
Secondary Insurance (if applicable)
Subscriber Name_____ Relationship to patient _____ Birth Date_____
Social Security #_____ Date Employed _____
Insurance Name_____ Insurance ID #_____ Group ID #_____

Notices

Please Initial Below:

_____ I have received a copy of Diamond Bar Dentals Materials Fact Sheet.

_____ I assign Diamond Bar Dental my right, title and interest in and to any and all dental benefits otherwise payable to me for oral health treatment rendered by assignee. I acknowledge that billing my insurance company for the services rendered is a courtesy done by Diamond Bar Dental. I am still responsible for paying the above referenced dentist to the extent the relevant insurer or payer does not pay the dentist full.

Patients Signature _____ **Date** _____

Signature of Patient (Parent/Guardian) _____

Signature of Dentist _____