Easton Bright Smiles
Cosmetic & Family Dentistry

New Patient Form

Welcome to Easton Bright Smiles! *We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following confidential form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.*

Patient Information

Patient's name ____ Preferred name ______________

If minor, parents names _______________________ Home phone ___________ Work phone ___________

Mailing address ________________________________ City _______________State ______ Zip ________

Sex: M F Age_____Birth date_________ Patient SS#______________________

Employer ____________________________ Occupation ____

Employer Address ____

Unmarried Married Divorced Widowed Seperated

Spouse's name _________________________ Spouse's employer __________________________

Spouse's Birthdate__________________________Spouse's SS#__________________________

Whom may we thank for referring you to our office? _______________________________________ ❑ Phonebook

Billing, Credit and Dental Insurance

❑ Not covered by dental insurance

Who is responsible for this account _________________________ Relationship to Patient___________________

Dental Insurance Co.______________ Group number__________

Covered by Additional insurance? Yes No

Subscriber Name______________________________Relationship to Patient________________________

Dental Insurance Company _____________________ Group Number ____________________________

Spouse's birthday ____________________________ Social Security number ______________________

ASSIGNMENT and RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with __________________________ and assign directly to Easton Bright Smiles PC all insurance benefits if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I am aware that if my account goes to an outside collection agency I will be responsible for additional collection charges. I hereby authorize Easton Bright Smiles PC to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Phone Numbers

Home____________________ Work____________________ Ext________Mobile____________________

Spouse Work______________________Ext________ Spouse Mobile______________________

Best Time and Phone Number to reach you____

In Case of Emergency, Contact (Specify somehow who does not live in your household)

Name______________________________Relationship to Patient_________________________

Home____________________ Work____________________ Ext________Mobile____________________