New Patient Information

Date________________________________

Name____ Male_____Female___
Last First Middle

Address____City_____________________________

State_____________Zip___________________ Home Phone#___________________________________

Business phone #___________________Cell phone #__________________ Preferred contact # h( ) b( ) c( )

Social Security_________________ Date of Birth____/_______/_______Occupation___________________
Mo day year

Email address_________________________________Referred by________________________________

Marital Status_______________________Spouses name if applicable_____________________________

Contact in case of emergency________________________ Responsible Party________________________

Relationship_______________________Emergency contact phone #______________________________

Chief Dental Complaint ____

Please bring your dental insurance card to the appt. This is often different from medical.

Dental Insurance Information: Primary cardholder's name_____________________________________

Cardholder's employer_____________________Cardholder's SS# or subscriber ID_____________________

Cardholder's Date of Birth_____/______/_________ Dental Ins. Co________________ Group #__________
Mo day year

Financial Policy: I understand that I am fully responsible for the balance of my account due at the time services are performed.
Signature____

Consent for treatment: I give Eric Schorn DDS and/or Amy Schorn DDS and delegate staff permission to perform procedures including but not limited to: giving anesthesia and medications, making radiographs and photographs, cleaning and exams, restoring and removing teeth, root canals and any other procedures necessary for my dental therapy.
Signature____