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NEW PATIENT FORM

Last Name _____ First Name _____ Middle Initial _____

Social Security # _____ Date of Birth _____ Marital Status _____ (M/S/D/W)

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

Employer _____ Address _____

City _____ State _____ Zip _____ Whom may we thank for referring you? _____

Who is your referring dentist? _____ Phone Number _____

Address _____ City _____ State _____ Zip _____ Name of person responsible for this account _____

In case of emergency, who should be notified? _____ Phone Number _____

Complete this section if dental insurance may assist in handling a portion of your account.

Insurance Carrier _____ Phone Number _____ Group Number _____

Address _____ City _____ State _____ Zip _____

Full Name of Employee _____ Social Security # _____ Date of Birth _____

Employer _____ Address _____

City _____ State _____ Zip _____ Relationship to Patient _____

Is the patient covered by additional insurance? ☐ Yes or ☐ No If YES...

Insurance Carrier _____ Phone Number _____ Group Number _____

Address _____ City _____ State _____ Zip _____

Full Name of Employee _____ Social Security # _____ Date of Birth _____

Employer _____ Address _____

City _____ State _____ Zip _____ Relationship to Patient _____

Complete this section ONLY if patient is a minor or full-time student:

School _____ Name of Parent or Legal Guardian _____

Address _____ City _____ State _____ Zip _____

Phone Numbers: Home _____ Work _____ Cell _____

I authorize treatment for this patient _____ (Parent or Legal Guardian)

Payment is due at the time of service, unless payment arrangements have been made in advance. Returned checks are subject to current NSF fees. Balances over 30 days are subject to Late / No Payment charges ($25.00, fee subject to change) and finance charges (1.5% monthly). Accounts that fall into delinquency will also be responsible for any and all costs incurred in the collection process including collection agency charges, attorney fees and court costs.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read and completed the information on this form. I certify that this information is true and correct to the best of my knowledge.

I hereby authorize Juzer Chinwalla D.D.S., M.S.D. to furnish information to insurance carriers concerning my diagnosis and treatments. I understand that I am fully responsible for all fees including any amount not covered by my insurance. I authorize the use of this signature on all insurance submissions:

Signature _____ Date _____