

New Patient Information

We are happy to have you join our great family of patients and friends. The benefits of a healthy and beautiful smile are immeasurable and our goal is to allow you to obtain the healthy smile you deserve.

About You

First Name	Last Name	Date of Birth
Gender	Marital Status	
	<ul style="list-style-type: none"> Married Single Divorced Separated Widowed 	
Address	City	Province Postal Code
Mobile Phone	Home Phone	Work Phone
		Parent/ Guardian if under 18
How did you hear about us?	Social Security #	Driver's License
Please take a picture of your photo id and text it to our office, 304-242-8600 and bring it with you to your appointment		
In Case of Emergency, we should notify:		
Name	Relationship	Phone

Dental Benefits

Insurance Coverage:	Secondary Insurance (If Applicable):
Yes No	Yes No
Name of Insuree:	Second Name of Insuree:
Relationship to Insured	Relationship to Insured
<ul style="list-style-type: none"> Self Spouse Child Other 	<ul style="list-style-type: none"> Self Spouse Child Other
Name of Employer	Name of Employer
Name of Ins. Co:	Second Name of Ins. Co:
Group/ Policy #:	Second Group/ Policy #:

Member ID:

Second Member ID:

Insuree DOB:

Second Insuree DOB:

Please take a picture of the front and back of your current dental insurance card(s) and text it to our office, 304-242-8600, ASAP so that we may start researching your dental benefits.

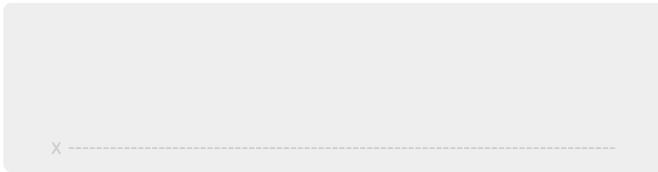
This form was signed by:

- Patient
- Parent
- Spouse
- Guardian
- Other

First & Last Name

Email Address

Signature

A rectangular box with a light gray background, intended for a signature. It contains a horizontal dashed line and a small 'x' character at the beginning of the line.