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

- 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:

- Yes
- No

Name of Insuree:

Relationship to Insured

- Self
- Spouse
- Child
- Other

Name of Employer

Name of Ins. Co:

Group/ Policy #:

Secondary Insurance (If Applicable):

- Yes
- No

Second Name of Insuree:

Relationship to Insured

- Self
- Spouse
- Child
- Other

Name of Employer

Second Name of Ins. Co:

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

X ----------