

# Library Park Dental

## New Patient Information:

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: H: ( ) \_\_\_\_\_ W: ( ) \_\_\_\_\_ Ext: \_\_\_\_\_ C: ( ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ SS#: \_\_\_\_\_

E-mail: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Primary Dental Insurance/Financial Information:

Name of Policy Holder/Responsible Party: \_\_\_\_\_

Patient's Relationship to Policy Holder: \_\_\_\_\_

Address of Policy Holder: \_\_\_\_\_  
*(if different from above)*

Policy Holder's Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
*(if other than patient)*

Policy Holder's **Employer**: \_\_\_\_\_

Policy Holder's **Insurance Company**: \_\_\_\_\_  
*(need a copy of the ins. card)*

Insurance ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
*(if on ins. card) (if on ins. card)*

Policy Holder's SS#: \_\_\_\_\_  
*(if different from above)*

Secondary Dental Insurance: \_\_\_\_\_ Yes \_\_\_\_\_ No  
*(need a copy of the ins. card)*

Consent: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care and to the use of my (or my child's) records to carry out treatment, obtain payment, and for those activities and healthcare operations that are related to treatment or payment.

Patient's or Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_