BRIDGE CITY
DENTAL

NEW PATIENT INFORMATION

Full Legal Name:_____ Preferred name (if different): _____

SSN:_____ Date of Birth:_____ Please circle: Male/Female

Home #: _____ Cell #:_____ Can we leave voicemails? YES / NO

Email Address:_____ Can we email you? YES / NO

Employer: _____

Home Mailing Address: _____

City:_____ State:_____ Zip:_____

Marital Status: (please circle) S/M/D/W Spouse:_____ SS#: _____

Emergency Contact's Name and phone number: _____

If a dependent, responsible party's name:_____

Phone: _____ Date of Birth: _____ SS#: _____

How did you hear about us? ☺ _____

Primary Dental Insurance Coverage

Subscriber: _____ SSN:_____DOB:_____
Relationship to Patient:_____ Employer: _____
Insurance Company: _____ Member ID: _____ Group No: _____

Secondary Dental Insurance Coverage

Subscriber: _____ SSN:_____DOB:_____
Relationship to Patient:_____ Employer: _____
Insurance Company: _____ Member ID: _____ Group No: _____

It is the policy of this office that charges are paid at the time of service. We will submit dental insurance claims, but you are responsible for any charges your insurance does not cover. In addition, we require a 24-hour notice to cancel an appointment. If you have canceled or missed three appointments without providing 24-hour notice, we may no longer schedule you at this office.

Please sign below to accept policy & responsibility.

Signature: _____ Date: _____