American Family Dental Care

NEW PATIENT FORM

Personal Information

Patient`s Last Name: First Name: Middle Name:

Address: City: State: Zip Code:

Email: Phone: The best way to reach me:

Birth Date: Age: Male/ Female: Marital Status:

Social Security Number: How did you hear about us?

Emergency Contact

Name of Emergency Contact: Relationship to Patient:

Home Number: Work Number: Cell phone:

Account Information

Person Financially Responsible for this account: Relationship to Patient:

SSN: Home Phone: Work Phone: Cell:

Email:

Employment Information

Occupation: Employer: Phone:

Address: City: State: Zip Code:

Dental Insurance Information

Name of the Insurance Company: Group number:

Employer Name:

Subscriber`s Name: Subscriber`s DOB: Subscriber`s relationship to patient:

Subscriber`s I.D number: Subscriber`s SSN:

Dental Customer Service phone (usually an 800#):

Secondary Carrier – Name of the Insurance Company: Group number:

Employer Name:

Subscriber`s Name: Subscriber`s DOB: Subscriber`s relationship to patient:

Subscriber`s I.D number: Subscriber`s SSN:

Dental Customer Service phone (usually an 800#):

105 N VIRGINIA AVE. STE 103 FALLS CHURCH, VA 22046 P: 703.533.7285 F:703.533.7287