kramer kirby d.d.s.

NEW PATIENT FORM

Personal Profile

First Name_____ Middle Initial_____

Last Name_____

Circle one: Male   Female

I like to be called_____

Circle one: Single   Married   Divorced   Widowed

Driver's License #_____

Date of Birth_____/_____/_____

SSN _____

Address_____City_____State_____

Zip_____

Home Phone_____   Cell Phone _____

Work Phone_____

Email_____

Name of Employer_____

How long employed? _____

Who may we thank for referring you to our practice?

_____

Account Information

Who is responsible for this account? _____

Relationship_____

Address_____ City_____

State_____ Zip_____

Home Phone _____Cell _____ Work_____

SSN _____   Date of Birth _____/_____/_____

Insurance Information – Primary

Insurance Company Name

_____

Phone _____   Group # _____

Insured's First Name_____ Middle Initial_____

Last Name_____

SSN _____   Date of Birth ____/____/_____

Insurance Information – Secondary

Insurance Company Name

_____

Phone _____   Group # _____

Insured's First Name _____ Middle Initial _____

Last Name _____

SSN _____   Date of Birth _____/_____/_____

In case of an emergency, please contact:

Name _____

Relationship to Patient _____

Home Phone _____ Cell _____ Work_____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I understand that my dental insurance carrier or the payor of my dental benefits may pay less than the actual cost of services. I understand that I am financially responsible for payments in full of all accounts. By signing this statement , I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental care payor. I attest to the accuracy of the information on this page.

Patient's or Guardian's Signature _____

Date _____