NEW PATIENT INFORMATION
CONLIN DENTISTRY

Patient's Legal Name____**Date of Birth**_______________

Mailing Address____

City/Prov/Postal____

Home Phone ___________________________________ **Cell Phone**____________________________

Email Address____

Whom may we thank for referring you?____

Person financially responsible for the account_____________________________

I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to the Conlin Dentistry. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize Conlin Dentistry to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance.

Patient's Signature______________________________________ **Date**____________________________
(if patient is a minor, a parent or guardian must sign)

MEDICAL ALERT:

Family Doctor Name: ______________________________ Phone:______________________________

In Case of Emergency, we should notify

Name:__________________________ Relationship:__________________ Phone: _________________

PRIMARY DENTAL INSURANCE:

Name of Dental Insurance____

Name of Policy Holder____ Date of Birth:__________________

Group#_________________________ Member ID#______________________________________

Employer:____ Phone:__________________________

May we call you at work Yes No May we leave a message Yes No

SECONDARY DENTAL INSURANCE:

Name of Dental Insurance____

Name of Policy Holder____ Date of Birth:__________________

Group#_________________________ Member ID#______________________________________

Employer:____ Phone:__________________________