Pearl White Dentistry
New Patient Information Form

Name: ______________________________________ Sex: ____ M ____F

Home Phone:______________________________Work Phone:__________________________________

Cell Phone:______________________________Email Address:________________________________

Home Address: ____

City:________________________Zip Code:________________State: ____________________________

Social Security #: ________________________ Date of Birth:__________________________________

Drivers License Number: ________________________________Exp. Date: _______________________

Reason for visit: ____

Employer Information
Employer Name and Address:
____

Employer Phone: ____

Spouse's Name:____ Work Phone:________________

Primary Care or Referring Physician: Phone: ____

Previous Dentist:_____________________________________ Phone:____________________________

Whom may we contact in the case of an emergency?______________________ Phone:_____________

Whom may we thank for referring you to us? ___________________________ Phone:______________

Who is responsible for this bill?____

Insurance Information
Name of Insured: ___________________________________Relationship to Patient:________________
Date of Birth:_____________ Social Security Number: ____
Name of employer: ______________________ Office Phone: ___________________________________
Insurance Company: _____________________ Group #:__________Employer/ID#
____
Insurance company address: ______________ City/State: _______________ Zip: ___________________
Do you have Secondary Insurance? ___Yes ___No
Name of Insured: ______________________________Relationship to Patient: ____________________
Date of Birth: _____________ Social Security Number: _______________________________________
Name of employer: ____________________________ Office Phone: ____________________________
Insurance Company: __________________________ Group #: _________Employer/ID# ___________
Insurance company address: _______________________ City/State: _______________ Zip: __________