Thank you for selecting New Hampshire Center for Comprehensive Dentistry for your dental healthcare! We promise that your experiences here will be comfortable, relaxed and enjoyable in all ways to the best of our ability.

Patient Information

First Name _____ Middle Initial _____ Last Name _____

By what name do you prefer us to call you? _____

Street Address _____Mailing Address (if different) _____

Town _____ State _____ Zip_____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

E-mail address _____

Date of Birth _____ Social Security Number _____ Single Married Divorced Widowed Separated Student

Emergency Contact Name _____ Day Phone (_____) _____Cell (_____) _____

Name of Employer _____ Employer Address _____

Appointment reminder preferences (please check all that apply): __ Home __ Office __ Cell Phone __ Text

May we leave messages on your answering machine or voice mail? __ Yes __ No

Whom may we thank for referring you to our practice? _____

If you found us through an online search, what were you looking for? _____

Dental Benefits Information

Policy Holder_____ Relationship _____ Date of Birth _____ SSN _____

Is this person currently a patient in this office? Yes No

Name of Employer _____

Insurance Company _____ Group ID # _____ Subscriber ID #_____

Insurance Company Address _____ Phone Number _____

Policy Holder_____ Relationship _____ Date of Birth _____ SSN _____

Is this person currently a patient in this office? Yes No

Name of Employer _____

Insurance Company _____ Group ID # _____ Subscriber ID #_____

Insurance Company Address _____ Phone Number _____

- *I consent to an examination by a dental provider. I understand that if treatment is recommended I will have opportunities to ask questions before accepting or refusing treatment.*
- *I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination provided to me or my child during the period of such dental care, to third party payors and/or health practitioners.*
- *I allow a photocopy of my signature to be used to process my insurance claims and will remain in effect until revoked by me in writing.*
- *I authorize and request my insurance company to pay directly to the dentist any dental benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I am responsible for any balances on my account.*
- *A photocopy of this assignment is to be considered as valid as the original.*

DRIVER'S LICENSE NUMBER _____ **SIGNATURE** _____