New Patient Information

Mark A. Moats, D.M.D

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential form. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us- we will be happy to help.

Whom may we thank for referring you?_____

ABOUT YOU

Name	I prefer to be called	Male	Female
Home Address	City	State	Zip

Home Phone #	Cell Phone #	Email Address

Would you be interested in having communications sent to you via your e-mail or by text message (example: appointment reminders) Email:_____yes _____no Text:_____yes_____no

Employer Name	Employer Phone	Employer Address	City	State	Zip

Birth date	Social Security Number

PERSON RESPONSIBLE FOR ACCOUNT

Only fill out this section if different from above

Name	Birth date	Social Security #	Relation to Patient

Billing Address	City	State	Zip

Home Phone	Work Phone	Cell Phone

Employer Name	Employer Address	City	State	Zip

SPOUSE INFORMATION/EMERGENCY CONTACT

Name	Home Phone	Work Phone	Cell Phone
Name	Home Phone	Work Phone	Cell Phone

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Company Name	Phone Number	Group/Policy Number
Insured's Name	Insured's Birth date	Relation

Insured's Social Security Number	Insured's Employer

Secondary Insurance

Insurance Company Name	Phone Number	Group/Policy Number
Insured's Name	Insured's Birth date	Relation

Insured's Social Security Number	Insured's Employer

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (patient's name) _____ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patients Signature_____Date_____

Parent/Responsible Party's Siganture_____Relationship to Patient_____