Trademark Dental

217 N Plymouth Ave, New Plymouth, ID 83655

New Patient Information:

Name_____Birth Date____/____/____ gender ___M___F
Home Phone_____Cell_____Work/School_____
Mailing address_____City_____ST_____ZIP_____
Is Texting OK___Y___N email_____Social Security#____-____-____
Emergency contact name_____phone_____
Minor/dependent consent: I consent to Flouride treatment___Y___N Digital X-rays as needed___Y___N
parent/guardian signature_____date____/____/____
print name_____
Party responsible for payment_____
Whom may we thank for referring you to our office?_____

Employer Information:

Employer Name and Address_____
Dental Insurance Company _____ID#_____
Address_____City_____ST___Zip_____ Ph____-____-_____
Subscriber name_____Date of Birth____/____/____ SSN_____-_____-_____
Group#_____Patient relationship to subscriber, _____child/dep. _____spouse
Secondary Dental Insurance
Compny_____ID#_____
Address_____City_____ST___Zip_____ Ph____-____-_____
Subscriber name_____Date of Birth____/____/____ SSN_____-_____-_____
Group#_____Patient relationship to subscriber, _____child/dep. _____spouse
Primary Medical Doctor_____Phone_____
Previous Dentist_____Last appointment date____/____/____

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