Date: _____ Account #: _____ (for internal use only)

Patient's Name: _____, _____, ____ Date of Birth: _____
(Last) (First) (MI)

S/S#: _____-_____-_____ M F (circle one)

(if a minor, name of parent/guardian): _____, _____, ____
(Last) (First) (MI)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____-_____ Cell: (_____) _____-_____ E-mail: _____

Contact Preferences: Text message ____ Telephone/Voicemail ____ E-mail ____ (check all that apply)

Please tell us how you heard about our practice (i.e. word of mouth or outside advertisement):

Name of referring Patient, Dentist or Insurance Carrier _____

Office Sign ___ Website ___ Other ___ (please explain) _____

*The following **patient** information is required by the Affordable Care Act (ACA)/Electronic Health Record (EHR):*

Preferred Language of Patient: _____

Patient Ethnicity: Hispanic or Latino ___ Not Hispanic ___ Declined to answer ___

Patient Race: American Indian or Alaska Native ___ Asian ___ Black or African American ___ White ___

Native Hawaiian/other Pacific Islander ___ Some other Race ___ Declined to answer ___

Primary Dental Insurance (if patient is a minor and both parents have coverage, the parent with the earliest birthday in the calendar year is primary)

Name of Policy Holder: _____, _____, ____ Date of Birth: _____
(if different from patient) (Last) (First) (MI)

S/S#: _____-_____-_____ M F (circle one) Name of Employer: _____

Insurance Company: _____ ID#: _____ Group#: _____

Phone: (_____) _____-_____

NJ Family Care Plan (or State assistance): A or B ____ C ____ D ____

Secondary Dental Insurance: (if patient a minor and both parents have coverage, the parent with the earliest birthday in the calendar year is primary)

Name of Policy Holder: _____, _____, ____ Date of Birth: _____
(if different from patient) (Last) (First) (MI)

S/S#: _____-_____-_____ M F (circle one) Name of Employer: _____

Insurance Company: _____ ID#: _____ Group#: _____

Phone: (_____) _____-_____

NJ Family Care Plan (or State assistance): A or B ____ C ____ D ____

Primary Medical Insurance:

Name of Policy Holder: _____, _____, ____ Date of Birth: _____
(if different from patient) (Last) (First) (MI)

S/S#: _____-_____-_____ M F (circle one) Name of Employer: _____

Insurance Company: _____ ID#: _____ Group#: _____

Phone: (_____) _____-_____

Secondary Medical Insurance:

Name of Policy Holder: _____, _____, ____ Date of Birth: _____
(if different from patient) (Last) (First) (MI)

S/S#: _____-_____-_____ M F (circle one) Name of Employer: _____

Insurance Company: _____ ID#: _____ Group#: _____

Phone: (_____) _____-_____