Welcome To Our Practice!

VALUE IMPLANTS & DENTURES

Please take a few moments to fill out the following forms so we can provide you with the best dental care!

New Patient Information

Patient Name _____ Date of Birth _____ Sex M ☐ F ☐

Home Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Can we text you? Yes ☐ No ☐

Best way to contact you? Home Phone ☐ Cell Phone ☐ Email ☐ Marital Status? Single ☐ Married ☐

Email _____ Can we email you? Yes ☐ No ☐

Emergency Contact Name _____ Phone _____

Relationship to Patient _____

How did you hear about our office? _____

Insurance Policy

If you do not have a subscriber ID, please enter your SSN

Your relationship to the Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID: _____

(Use your SSN if necessary)

Employer: _____ Retired ☐

Insurance Company: _____ Phone: _____

Group Name: _____ Group #: _____

Please complete the next page to the best of your ability.