New Patient Form: (Please Print) Date:_____

First: _____ Middle:_____ Last:_____ Jr/Sr: _____

Address: _____ Apt. #_____ City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ -_____*Would you like to receive friendly appointment reminders via text? □Yes or □ No

Email Address: _____ @ _____ *May we contact you by Email? □ Yes or □ No

Patient Social Security Number: _____- _____ - _____ Sex: □**Male or** □**Female**

Patient Date of Birth: _____/_____/_____ Driver's License #: _____ State:_____
Month Day Year

Emergency Contact Name: _____ Phone: (_____) _____ - _____

How did you hear about Metro Smiles? □Patient Referral: If So, Patient Name _____
□Internet (Google, Yelp, Facebook, Twitter) Insurance Company □Flyer □Walk-In □Driving By
□Website: www.mymetrosmiles.com □1-800-DENTIST □Other: _____

Insurance Information

Do you have Dental Insurance? □**Yes or** □**No**

Primary Insurance

Subscriber Name
_____

Subscriber SSN _____ - _____ - _____

Date of Birth _____/_____/_____

Relationship to Subscriber □Self □Spouse □Child □Other

Employer Name _____

Insurance Company _____

Member ID # _____

Insurance Group # _____

Insurance Phone (_____) _____ - _____

Do you have Secondary Dental Insurance? □**Yes or** □**No**

Secondary Insurance

Subscriber Name
_____

Subscriber SSN _____ - _____ - _____

Date of Birth _____/_____/_____

Relationship to Subscriber □Self □Spouse □Child □Other

Employer Name _____

Insurance Company _____

Member ID # _____

Insurance Group # _____

Insurance Phone (_____) _____ - _____

Please present card to receptionist to be photocopied

Here at Metro Smiles we understand that affordability is an important consideration in getting the dental treatment you need and deserve. We offer a variety of payment plan options so that your treatment is within reach. Would you be interested in hearing more about our 6-12 months payment plans ***(upon approval)***? □Yes or No

If Patient Is Under 18 Years Of Age

Responsible Party Name: _____ Relationship to Patient:_____

_____ _____
Patient or Parent/Legal Guardian Signature Date