SHAPIRO DENTAL

Today's Date:_____

New Patient Form

Welcome to Shapiro Dental. We are happy you have chosen our practice as your dental home. Our team looks forward to working with you and building a professional relationship with you and your teeth. Please provide any insurance cards to the front desk.

Patient Information

Patient Name:_____ DOB:_____ Gender:_____

Address:_____ City:_____ State:_____

Email Address:_____ SSN:_____ ZIP:_____

Cell Phone:_____ Home Phone:_____

Employer/School:_____ Phone:_____

Pharmacy:_____ Phone:_____

Emergency Contact(s)

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

Insurance Information

Subscriber Name:_____ Relation:_____

Subscriber DOB:_____ Subscriber SSN:_____

Insurance Company:_____

Member ID:_____ Group #:_____

Claim Mailing Address:_____

Provider Support Phone Number:_____

We require the above information so that Shapiro Dental can help obtain the dental insurance benefits our patients are eligible for. This may require submitting the Doctor's treatment plan to the insurance company(s) for a **predetermination** of benefits, or in some cases obtaining the information by phone and internet. We can **NEVER** guarantee payment by your insurance company. The insurance company's contract is with you and/or your employer.

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Financial and Procedure Policies

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information on the Patient Information Form is true and correct to the best of my knowledge. I will notify Shapiro Dental of any changes in my health status or any changes in the above information. I understand that missed appointments may result in a $40 missed appointment fee and that I should inform Shapiro Dental of any appointment changes 24 hours in advance. I authorize routine dental diagnostic procedures. If I accept the proposed treatment plan, I also agree to the use of local anesthetics and pre-medications considered necessary or advisable by the doctor for my comfort and well being.

How did you hear about us? _____

Patient (Guardian) Signature: _____ **Date:** _____