

## NEW PATIENT FORM

### Patient Information

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ Social Security # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Sex  Male  Female

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

*Who may we thank for referring you?*

### Financial Responsibility *(Complete if other than the patient or if the patient is under 18)*

Person financially responsible for the account \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Relationship to the Patient:  Parent  Spouse  Guardian  Other

### Dental Insurance Information

#### *Primary Dental Insurance*

#### *Secondary Dental Insurance*

Insurance company with address	Insurance company with address
Employee/Subscriber Name	Employee/Subscriber Name
Employee/Subscriber SS #	Employee/Subscriber SS #
Employee/Subscriber Date of Birth	Employee/Subscriber Date of Birth
Group #	Group #
Employer Name and telephone	Employer Name and telephone

### Emergency Contact

Person to contact in case of emergency \_\_\_\_\_ Telephone \_\_\_\_\_



**Anthony Toney, DMD, P.C.**  
**Family Dentistry**  
*'Beautiful smiles through exceptional dentistry'*

2585 Sparkman Drive Huntsville, AL 35810 Phone: 256.652.6161

*I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Dr. Anthony Toney. I understand that I am financially responsible for all charges whether or not paid by the insurance. I authorize Dr. Anthony Toney to release all information necessary to secure payment. It is my responsibility to pay any deductibles, co-payments and any other fees not paid by insurance. I understand payment is expected at the time of service.*

Patient's Signature \_\_\_\_\_  
*(If patient is a minor, a parent or guardian must sign.)*

Date \_\_\_\_\_