WONDER
FAMILY DENTAL & DENTURES

19410 8th Ave NE Suite 102 Poulsbo, WA 98370
Phone: (360) 779-1566 | Fax: (360) 779-6879

NEW PATIENT INFORMATION

PATIENT INFORMATION

Name: _____ Preferred Name: _____ DOB: _____

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

Home Phone: _____ Cell Phone: _____ SSN: _____

Email: _____ Would you like text and/or email reminder?: ◯ Yes ◯ No

Preferred contact method(s): ◯ Phone ◯ E-mail ◯ Text

Information we can leave via voicemail, email, or text: ◯ appointment ◯ financial/account balance ◯ treatment info

If patient is a minor, give parent's or guardian's name: _____

Please check one: ◯ Minor ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Separated

Patient's Employer: _____ Work Phone: _____

Spouse's Name: _____ Employer: _____ Work Phone: _____

Whom may we thank for referring you to our office?: _____

Emergency Contact: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Name of Subscriber: _____ Relationship to Patient: _____

DOB: _____ SSN: _____

Insurance Company: _____ Group Number: _____ Policy ID: _____

-- If you have dual coverage, please complete section below --

Name of Subscriber: _____ Relationship to Patient: _____

DOB: _____ SSN: _____

Insurance Company: _____ Group Number: _____ Policy ID: _____

ACCIDENT OR INJURY INFORMATION (To be completed if the reason for today's visit is due to an accident)

Please provide details of the accident

Date and Location: _____

Details of accident or injury: _____

_____

Have you consulted another physician regarding any injuries resulting from this accident? _____

Patient Signature: _____ **Date:** _____