

Steven A. Fischman, D.M.D.

9 Dale Street

West Hartford, CT 06107

860-236-8376

NEW PATIENT INFORMATION

SECTION 1- PATIENT INFORMATION

Patient name: _____ Nickname: _____
Date of birth: _____ Age: _____ Sex: male female
School _____ -or- Employer: _____
Address: _____ Phone: _____
 House, apt. # Street

City State Zip Email: _____
Dentist name and address: _____
Referred by: _____
Chief complaint: _____
Has patient seen an orthodontist previously? _____

SECTION 2 - PARENT/GUARDIAN INFORMATION (FOR MINOR PATIENTS ONLY)

Parent/Guardian name: Mrs./Ms./Miss/Mr./Dr. _____
Marital status: single married separated divorced widowed
Address if different than above: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____

Parent/Guardian name: Mrs./Ms./Miss/Mr./Dr. _____
Marital status: single married separated divorced widowed
Address if different than above: _____
Home phone: _____ Cell phone: _____
Work phone: _____ Email: _____

SECTION 3 - DENTAL INSURANCE

Dental Insurance: _____ Ins. Co. phone: _____
Member ID# or SSN: _____ Member date of birth: _____
Employer: _____

Dental Insurance: _____ Ins. Co. phone: _____
Member ID# or SSN: _____ Member date of birth: _____
Employer: _____

Signature(s) of RESPONSIBLE Party(s) for billing:

X _____ Date: _____
X _____ Date: _____

I have received a copy of this office's Notice of Privacy Practices.

Name: (Print) _____ Signature: _____ Date: _____

OFFICE USE ONLY

Patient/Guardian refused to sign
 Communications barriers prohibited obtaining the acknowledgement
 An emergency situation prevented us from obtaining acknowledgement
 Other (describe) _____