



NEW PATIENT FORM

Name: _____ Date of Birth: _____

Preferred Name: _____ Gender: _____

Social Security Number: _____ Marital Status: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Mobile Phone #: _____

Email: _____

How did you hear about us?: _____

Employer: _____ Occupation: _____

Preferred Pharmacy: _____

Major Cross Streets: _____

EMERGENCY CONTACT INFORMATION

Name: _____

Phone #: _____ Relationship: _____



DENTAL INSURANCE

Do you have Dental Insurance?: YES ☐ NO ☐

Dental Insurance Company Name : _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Subscriber ID/SSN: _____

Policy Holder Employer: _____

Patient Relationship to Policy Holder: _____

Claims Address (back of card): _____

Group #: _____ Phone #: _____

Do you have Secondary Dental Insurance: YES ☐ NO ☐

Dental Insurance Company Name : _____

Policy Holder Name: _____

Policy Holder Date of Birth: _____ Subscriber ID/SSN: _____

Policy Holder Employer: _____

Policy Holder Address (if not same as patient): _____

Patient Relationship to Policy Holder: _____

Claims Address (back of card): _____

Group #: _____ Phone #: _____



Acknowledgment of Receipt of Notice of Privacy Practices

I, the undersigned, acknowledge that I have received, read, and understand the Notice of Privacy Practices provided by Sandia View Family Dental. I understand that this notice describes how my medical information may be used and disclosed, and how I can access this information.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

Acknowledgment of Financial/Office Policy

I, the undersigned, acknowledge that I have received, read, and understand the Financial Policy of Sandia View Family Dental. I understand my financial responsibilities regarding services rendered by this practice, including payment for services, insurance billing procedures, and any applicable fees.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____



ELECTRONIC CONSENT FORM

This form is used to obtain your consent to communicate with you by mobile text messaging and email regarding your Protected Health Information.

Sandia View Family Dental offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Sandia View Family Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Sandia View Family Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

By signing below, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Sandia View Family Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Sandia View Family Dental.

Patient Name (Printed): _____

Patient Signature: _____

Date: _____