Michelle McClintock DDS PA
Cosmetic, Implant and Family Dentistry

New Patient Information

Please complete all fields. If any item does not apply, please write N/A.

Patient Full Name:_____

Age:_____ Date of Birth:_____ Sex:_____

SSN:_____ Marital Status:_____

Home Address:_____

City:_____ State:_____ Zip Code:_____

Home #_____ Cell #_____

Email:_____

Patient's Employer: _____ Work #_____

Primary Doctor's Name:_____ Phone# _____

Complete ONLY if patient is a minor or student

Mother's Name:_____
SSN:_____ DOB:_____
Employer:_____
Work # _____

Father's Name: _____
SSN:_____ DOB:_____
Employer:_____
Work # _____

Emergency Contact

Name:_____ Phone:_____

Primary Insurance

Insurance Company's Name: _____

Policy Holder's Name: _____

Employer: ____

SSN: ____________________________________ DOB: _________________________________