Fonseca Dentistry
John F. Fonseca, D.D.S.

# New Patient Information

| Patient Name | Home Address | City, State, Zip |
|---|---|---|
| Home Phone | Social Security No. | Birth date |
| Cell Phone | Email | Sex (Check One):<br>☐ Male ☐ Female |
| Work Phone | Marital Status (check one):<br>☐Single☐ Married☐Divorced☐Other | Contact Preferences (check all that apply)<br>☐Email ☐Text ☐Phone |
| Employer | Occupation | |

**Insurance: ☐ I have secondary insurance. (Please ask us for the secondary insurance form)**

| Primary Insurance Company | Group No. | ID No. |
|---|---|---|

**Insurance Subscriber Information (If different from patient):**

| Patient Name | Home Address | City, State, Zip |
|---|---|---|
| Home Phone | Social Security No.<br><br>Birthdate | Driver's License No. |
| Cell Phone | Email | Sex (Check One):<br>☐ Male ☐ Female |
| Work Phone | Marital Status (check one):<br>☐Single☐ Married☐Divorced☐Other | Contact Preferences (check all that apply)<br>☐Email ☐Text ☐Phone |
| Employer | Occupation | Relation to Patient |

**Responsible Party (if different from above):**

| Name | Birthdate |
|---|---|
| Social Security No | Driver's License No. |

How did you hear about our office? _____

**Communication and Release**

I hereby authorize and request any exam, x-rays, or diagnostic aids deemed necessary to make a thorough diagnosis. Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and employ such assistance, as necessary. I agree to the use of anesthetics, sedatives, and other medications as necessary and understand that using these embody certain risks. I understand that I can ask for a complete recital of any possible complications.

I acknowledge that I have reviewed the Notice of Privacy Policies, can get a copy upon request, and consent to the use of my Personal Health Information for the purposes of health-care operations, treatment, referrals, and payment activities.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment**. I understand if I miss or cancel an appointment with less than 48-hour notice, there will be a failed appointment fee of $50/hour booked, which I agree to pay before any further appointments can be made.**

**Signature:**

_____ _____

Patient/Parent/Responsible Party Date

(I have read and agree to the content, terms, and conditions listed above**)**