Pamela G. Doray, DMD
UNCOMPROMISING CARE. EXQUISITE RESULTS.

New Patient Welcome Form

**About You** Today's Date: ______________

Email Address: _______________________________________

Name: ____________________________________________

I prefer to be called: __________________________________

Birthdate: ___/___/ ____ Age: ___ SS# ____________________

Home Address: _______________________________________

__________________________________________________

__ Single __Married __Partnered __Divorced/Separated __Widowed

Home #:_________________ Cell#:_____________________

Work # __________________ Ext:_______

Where & when are best times to reach you? _______________

Employer:__________________________________________

Employers Address:___________________________________

__________________________________________________

How long there?______ Occupation______________________

Whom may we thank for referring you? ___________________

Other family members seen by us:_______________________

Previous/Present Dentist: _____________________________

Phone #___________________________________________

**Spouse Information / Emergency Contact**

His/Her Name:______________________________________

Employer:__________________________________________

Wk#_________________ Ext_______ SS#_______________

Relative or Friend not living with you

His/Her Name:______________________________________

Wk# ___________________ Home#____________________

**Primary Insurance**

Do you have dental Coverage __Yes __No

Insurance Co. Name:__________________________________

Subscriber Name: ___________________ Relation:_________

Subscriber bday: ___/____/____ ID:_____________________

Group #:____________________________________________

Subscriber Employer:_________________________________

**Secondary Insurance**

Dental Coverage __Yes __No

Insurance Co. Name:__________________________________

Subscriber Name: ___________________ Relation:_________

Subscriber bday: ___/____/____ ID:_____________________

Group #:____________________________________________

Subscriber Employer:_________________________________

**Payment is due in full at the time of treatment**
unless prior arrangements have been approved.

If you have dental benefits, we will submit your claim as a courtesy for you. However, payment in full is due at the time of service unless prior payment arrangements have been made. Please be aware, not all services are covered by all insurance policies and the "usual and customary charges" quoted by your benefits carrier does not necessarily reflect our fees.

I hereby authorize release of any information, including diagnosis and records of treatment or examination rendered, to my insurance company.

As health care providers, our relationship is with you, not your insurance company. While filing insurance claims for our patients is a courtesy, I understand that I am responsible for all costs of dental treatment.

__________________________________________________

Signature Date