



KENNEDY DENTAL GROUP  
 JEFFREY R. KENNEDY, DDS  
 RICHARD W. WAGNER, DMD

# WELCOME

## New Patient Information and Insurance Form

FILL IN ALL INFORMATION BELOW.

Who may we thank for referring you to us? \_\_\_\_\_

**Patient:**

Dr. Mr. Mrs. Ms. Miss

|                                            |                        |                |                |
|--------------------------------------------|------------------------|----------------|----------------|
| Last Name                                  | First                  | MI             | Preferred Name |
| Street Address                             | City                   | State          | Zip Code       |
| Date of Birth                              | Social Security Number | Home Phone     |                |
| Employer                                   | Employers Address      | Work Phone     |                |
| If you are a college student, college name |                        | E-mail address |                |

Marital Status \_\_\_\_\_ Spouse's name \_\_\_\_\_

**Responsible Party:**

Dr. Mr. Mrs. Ms. Miss

|                                          |                        |                                 |                         |                        |
|------------------------------------------|------------------------|---------------------------------|-------------------------|------------------------|
| Last Name                                | First                  | MI                              | Relationship to Patient |                        |
| Street Address                           | City                   | State                           | Zip Code                |                        |
| Date of Birth                            | Social Security Number | Driver's license state & number |                         |                        |
| Employer                                 | Employers Address      | Work Phone                      |                         |                        |
| Insurance Company Name and Policy Number |                        | Group Number                    | Insurance Member ID     |                        |
| Insurance address                        | City                   | State                           | Zip Code                | Insurance phone number |

I understand all charges are due at the time of service unless other payment arrangements have been approved by Kennedy Dental Group. I have read and understand the financial policy.

I authorize Kennedy Dental Group to release my personal information to third parties solely for purposes of insurance filing.

Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Please complete the following medical and dental history questionnaire.