



Green Mountain Dental Sleep Center - New Patient Form

Patient Information

Mr./Ms./Mrs./Dr. First Name: _____ Last Name: _____ MI: ____
 Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
 The best time to contact me is: Morning Mid-Day Evening on Home phone Cell phone Work phone
 Email Address _____ Would you like to receive our e-newsletter? Yes No
 Address: _____ City: _____ State: _____ Zip: _____
 Date of Birth (M/D/Y): ____ / ____ / ____ Gender: M F Social Security Number (SSN): _____
 Height: Feet ____ Inches ____ Weight (lbs): ____ Marital Status: Married Single Life Partner Minor
 Spouse or Parent/Guardian (if minor) Name: _____
 Emergency Contact: _____ Relationship: _____ Phone _____
 REFERRED BY: _____

Employer Information

Employer: _____ Phone: (____) _____ Fax: (____) _____
 Address: _____ City _____ State: _____ Zip: _____

Health Insurance Information

Patient's Relationship to Primary Insured: Self Spouse Child Other
 Name of Insured (First, MI, Last): _____ Insured DOB (M/D/Y): ____ / ____ / ____
 Ins Co.: _____ Ins ID: _____
 Group #: _____ Plan Name: _____
 Business Address _____ City _____ State: _____ Zip _____
 Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your insurance card so we can photocopy it.

Secondary Health Insurance

DO YOU HAVE SECONDARY INSURANCE? YES NO IF **YES**, PLEASE COMPLETE THIS SECTION
 Patient's Relationship to Insured: Self Spouse Child Other
 Name of Insured (First, MI, Last): _____ Insured DOB ____ / ____ / ____
 Ins Co.: _____ Ins ID: _____
 Group #: _____ Plan Name: _____
 Business Address _____ City _____ State: _____ Zip _____
 Phone: (____) _____ Fax: (____) _____ Email: _____
Please present your secondary insurance card so we can photocopy it.

Medical Contacts

Dental Sleep Solutions® coordinates treatment with your other medical providers to ensure maximum benefit to you. Where applicable, please list your other medical providers.

PRIMARY CARE DOCTOR: _____ Phone: _____
 ENT: _____ Phone: _____
 SLEEP DOCTOR: _____ Phone: _____
 DENTIST: _____ Phone: _____
 OTHER MD: _____ Phone: _____
 OTHER MD: _____ Phone: _____

I certify this information is true, accurate, and complete to the best of my knowledge. INTIAL: _____ Date: _____