Curtis A. Brookover
D.D.S., FAGD, AF-AAID

Integrative Dentistry of New Mexico

New Patient Information

Welcome to our office! We would like to get to know you as our patient. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please let us know. If you have any questions please do not hesitate to ask.

Patient Name: ____ **Date of Birth:**____________________

Marital Status: ☐ **Single** ☐ **Child** ☐ **Married** ☐ **Divorce** ☐ **Separated**

Gender: ☐ **Male** ☐ **Female** **Social Security Number:** ______________________________

Home Address: ____

City: ____________________________ **State:** ____________________ **Zip Code:** ________________

Primary Phone #: (_______) ________________ **Work Phone #:** (_______) ____________________

Email Address: ____

Preferred Contact Method: ☐ **Call** ☐ **Text** ☐ **Email**

Is the Patient under the age of 18? ☐ **Yes** ☐ **No**

Responsible Party Information (Primary insurance holder or parent of minor)

Name: ____ **Date of Birth:** ____________________

Relationship to Patient: _______________________________ **S.S. Number:** ____________________

Employer: ____

Primary Phone #: (_______) ________________ **Work Phone #:** (_______) ____________________

How did you hear about our Office?

☐ **Referred by a friend** ☐ **Postcard or Letter** ☐ **Health Fair/Community Event**

☐ **Insurance Plan** ☐ **Newspaper/Magazine** ☐ **Drive By/Office Sign**

☐ **On-Line** ☐ **Radio** ☐ **Other**_________________________

If you were referred to our office, whom may we thank for referring you?

____

Patient Initials ________