

Joy Dental Associates
89 N Maple Ave, Ridgewood, NJ 07450
201-797-8899, office@smilebyjoy.com

New Patient Information

Patient Name _____ **Birth Date** _____
First MI Last

Address _____

Social Security# _____ Gender M F Occupation _____

Cell # _____ Alternate # _____ E mail _____

Emergency Contact Name _____ Relationship _____

Tel# _____

How did you find us? Internet site Google, Yelp, Zocdoc, Healthgrade, Other Site _____

Referred by _____, Insurance, Sign, Other _____

If you do not have a dental insurance, skip to Office Policies.

If you have a secondary coverage, please ask front desk for additional form.

Dental Insurance Company _____ Tel# _____
Patient's Relationship to Primary Holder <input type="checkbox"/> Self <input type="checkbox"/> Dependent (if self, skip to Name of Employer)
Primary Holder's Name _____ Social Security # _____
Birth Date _____
Name of Employer _____ Group# _____ ID# _____

Office Policies

- Notice of Privacy Practices; your privacy is important to us. Your information will be kept confidential all the time. We will use it for only healthcare operations permitted by law.
- Financial Agreement; payment is due at the time of service unless other agreement is satisfied.
- Appointment reminder, confirmation and other messages will be communicated by phone, text or e mail. If you prefer not to have electronic communication, you may opt out.
- Patient should update address and contact info as well as insurance whenever it is changed.
- We reserve rights to charge cancellation fee unless notified 48 hours prior to the appointment.

Patient Signature _____ Date _____

If minor, Parent or Guardian Name _____ Tel _____

Signature _____ Date _____