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, Facebook, 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 □ Self □ 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 _____