Springhill Dental and Orthodontics
637 NW Hickory St #110, Albany, OR 97321
(541) 406 3500
springhilldentalalbany.com

NEW PATIENT FORM

Basic Information

First Name:	Gender:	☐ Male ☐ Female ☐ Other
Last Name:	DOB:	
Preferred Name:	Marital Status:	☐ Single ☐ Married ☐ Child
SSN #:		☐ Widowed ☐ Divorced
Referral Source:	Employer:	
Referred by:	Occupation:	

Contact Information

Mobile Phone:
Home Phone:
Email:

Address Information

Street Address:
City:
State:
ZIP:

Emergency Contact

Full Name:
Phone Number:
Relation:

Work Information

Street Address:
City:
State:
ZIP:

Primary Insurance Information

Do you have a dental insurance? ☐ Yes ☐ No

Patient's Relationship to the Insurance Holder: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Policy Holder's Name:
Policy Holder's DOB:
Policy Holder's SSN:
Policy Holder's
Policy Holder's City:
Policy Holder's State:
Policy Holder's ZIP:
Policy Holder's Phone Number:
Policy Holder's Employer:
Dental Insurance Company:
ID Number:
Group Number:
Phone number on the back of your insurance card:
Address on the back of your insurance card:

Secondary Insurance Information

Do you have a secondary dental insurance? ☐ Yes ☐ No

That's all! If you would like to add secondary insurance, you need to provide primary insurance first.

Patient's Relationship to the Insurance Holder: ☐ Self ☐ Spouse ☐ Child ☐ Dependent

Policy Holder's Name:

Policy Holder's DOB:

Policy Holder's SSN:

Policy Holder's

Policy Holder's City:

Policy Holder's State:

Policy Holder's ZIP:

Policy Holder's Phone Number:

Policy Holder's Employer:

Dental Insurance Company:

ID Number:

Group Number:

Phone number on the back of your insurance card:

Address on the back of your insurance card:

Patient/Guardian Signature: Date: 09/16/2025