



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:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
Last Name:	DOB:			
Preferred Name:	Marital Status:	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Child
SSN #:		<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	
Referral Source:	Employer:			
Referred by:	Occupation:			

### Contact Information

Mobile Phone:	Street Address:
Home Phone:	City:
Email:	State:
	ZIP:

### Address Information

### Emergency Contact

Full Name:	Street Address:
Phone Number:	City:
Relation:	State:
	ZIP:

### Work Information

### Primary Insurance Information

Do you have a dental insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Patient's Relationship to the Insurance Holder:	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> 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