Newberg Family Dental

Dr. Randy Morgan, DMD
615 E. 2nd St. Newberg, OR 97132 503.538.7717

Date _____

Patient Name _____ Date of Birth _____
First Middle Last

Address _____ Marital Status _____S _____M _____D _____W

City _____ State _____ Zip Code _____

Home Phone # _____ Work Phone # _____

Cell Phone # _____ Email _____

Social Security # _____ Occupation _____

Employer's Name _____

Referred By: ☐ Insurance ☐ Internet ☐ Phone Book ☐ Graphic
☐ Name of Friend/Family Member:_____ ☐ Other_____

If patient is a child, please complete the following:

Mother's Name _____ Date of Birth _____

Address _____ SSN _____

Father's Name _____ Date of Birth _____

Address _____ SSN _____

DENTAL INSURANCE INFO

Primary Insurance: Name/Subscriber _____

ID/Social Security # _____ Date of Birth _____

Insurance Company _____

Address _____

Phone # _____ Group # _____ Policy # _____

Secondary Insurance: Name/Subscriber _____

ID/Social Security # _____ Date of Birth _____

Insurance Company _____

Address _____

Phone # _____ Group # _____ Policy # _____

I authorize the Doctor to take any diagnostic aids he/she deems necessary to make a through diagnosis of my dental needs and to perform any and all forms of treatment, medication, and therapy that may be indicated utilizing assistance as appropriate. I understand that I am responsible for all fees, regardless of insurance benefit coverage, collection, or attorney fees. Payment is due and expected at the time services are rendered unless other financial arrangements have been made with our office in advance.

Signature _____