HOWARD Family Dental®

New Patient Registration

Patient's Name _____ Preferred Name _____

Sex: ❑ M ❑ F Date of birth ___/___/___ SSN _____

Please check one: ❑ Single ❑ Married ❑ Separated ❑ Widow

Home Address _____ City _____ State _____ Zip _____

Email Address _____

Home phone # _____ Work Phone # _____

Cell Phone # _____

Person Responsible for Account ❑ Same as Above _____

Date of Birth ___/___/_____ Email address _____ Phone _____

How did you hear about our office? ❑ From another patient

Name of Person or Office Referring you to our practice? _____

❑ Dental Office ❑ Newspaper/Magazine ❑ TV/Radio ❑ Billboard ❑ School ❑ Work ❑ Insurance

❑ Other _____

Emergency Information

Name of person to contact in the event of an emergency _____

Phone # _____

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name _____

DOB _____ SSN _____

Insured's Employer _____

Insurance Company _____

Phone # _____

Group # _____

If you have secondary insurance coverage, complete this for the second coverage

Insured's Name _____

DOB _____ SSN _____

Insured's Employer _____

Insurance Company _____

Phone # _____

Group # _____