New Patient Registration

Patient's Name ______________________ Preferred Name ______________________

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

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

Home Address ______________________ Apt # ______ 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 # ______________________