NEW PATIENT REGISTRATION

Today's Date _____________

Email Address ________________________________

Patient's Name ______________________________________
LAST FIRST MI

Date of Birth__________ SSN: _________________

Preferred Name ______________________________________

Home Address _______________________________________

City ____________________ State _______ Zip __________

If Child, Parent's Name ________________________________

If Student – Full Time ______ Part Time _______

Name of School _______________________________________

Telephone: Home ___________________________

Work ___________________________

Cell _____________________________

DO YOU WISH TO RECEIVE TEXT REMINDERS/NOTIFICATIONS? Y OR N

DO YOU WISH TO RECEIVE EMAIL REMINDERS/NOTIFICATIONS? Y OR N

Primary Care Physician _____________________________

Phone Number _____________________________

Patient Employer __________________________________

Employer Phone Number _____________________

Spouse's Name ____________________________________

Spouse's Phone Number ______________________

EMERGENCY CONTACT (other than spouse)

Name _______________________________________ Phone Number ___________________ Relation _______________

Whom may we thank for referring you? ____

Other family members in this practice ____

PRIMARY INSURANCE COVERAGE

Member ID# ______________________________

Plan Group# __________________________

Policy Holder Name _________________________ Birthdate ___________ Policy Holder's SS# _________________________

Relation to Patient __________________ Policy Holder Employer ____

Insurance Co. Name _____________________________________

Phone Number _______________________

Insurance Co. Mailing Address ____

SECONDARY INSURANCE COVERAGE (if applicable)

Member ID# ______________________________

Plan Group# __________________________

Policy Holder Name _________________________ Birthdate ___________ Policy Holder's SS# _________________________

Relation to Patient __________________ Policy Holder Employer ____

Insurance Co. Name _____________________________________

Phone Number _______________________

Insurance Co. Mailing Address ____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS NECESSARY FOR PROPER DENTAL CARE AND I ATTEST TO THE ACCURACY OF THE INFORMATION ON THIS PAGE:

Patient/Guardian Signature ________________________________ Date ___________________