

New Patient Registration

PATIENT INFORMATION:

First Name: _____ Last Name: _____

Birth date: _____ SS# _____ Sex: Male Female Marital Status: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email address: _____

Would you like to receive email correspondence? Yes No

Whom may we thank for referring you to our office? _____

In Case of an emergency who can we contact? _____

Relationship: _____ Phone number: _____

RESPONSIBLE PARTY INFORMATION (if patient is a minor):

Name: _____ Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Birth date: _____ SS# _____ Marital Status: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

INSURANCE INFORMATION:

Primary:

Insurance Company: _____

Subscriber Name: _____ Birth Date: _____ SS#: _____

Occupation: _____ Employer: _____ Employer Phone Number: _____

Secondary:

Insurance Company: _____

Subscriber Name: _____ Birth Date: _____ SS#: _____

Occupation: _____ Employer: _____ Employer Phone Number: _____

DENTAL HISTORY:

Dental reason for coming to our office (e.g. pain, cleaning, ect.): _____

Name general dentist: _____

Address: _____ Phone: _____

Date of last cleaning: _____ Current x-rays: _____