New Patient Registration Form

Date:_____

Patient Last Name: _____First Name: _____ M.I.:____

Street: _____

City: _____ State: _____ ZIP: _____

Home PH#: _____ Work PH#: _____

Cell #: _____ Emergency PH#: _____

DOB: _____ ☐ Male ☐ Female SS#: _____

Marital Status: ☐ Single, ☐ Married, ☐ Widowed, ☐ Separated, ☐ Divorced

E-Mail: _____

Spouse / Parent's Name: _____

Purpose of Visit: ☐ Emergency ☐ Regular ☐ Other _____

If Student: ☐ Full Time ☐ Part Time School Name: _____

Previous Dentist's Name: _____ Phone #: _____

Insurance Policy Holder's Information

Last Name: _____ First Name: _____M.I._____

Name of Insurance Company: _____

Type of insurance: ☐ PPO, ☐ HMO/DMO, ☐ Union, ☐ Discount Plan, ☐ Other

Group Number: _____ Member ID: _____ SS#: _____

Date of Birth: _____ Insurance Effective Date: _____

Employer Name: _____

Employer Address: _____

Employer Phone #: _____

Relationship with primary member: ☐ Self, ☐ Spouse, ☐ Child, ☐ Other

How did you hear about our office?: ☐ Online ☐ Mailer ☐ Family Member ☐ Current Patient

☐ Insurance Website ☐ Co-Worker ☐ Church Bulletin Other _____