New Patient Registration Form

Date: ____________________

Patient: Last Name: ______________________________First Name: ________________ M.I.:_____

Street: ____

City: ____ State: ________ ZIP: ________________

Home PH#: ____________________________ Work PH#: __________________________________

Cell #: _______________________________ Emergency PH#: _______________________________

DOB: ________________ Gender ☐ Male ☐ Female SS#: _________________________

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced
☐ Widowed ☐ Domestic Partnership

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 _______________________________