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New Patient Registration

Welcome! Your confidential answers to the following questions will help to establish you as a patient at this office.

Today's Date ____________________

Patient Name ______________________________
First MI Last

Date of Birth ____________ Age ________ Gender: ◯ Male ◯ Female
mm/dd/yy

Home Address ______________________________
Street City State Zip

Home Phone ( ) ____________ Work Phone ( ) ____________

Cell Phone ( ) ____________ Pager # ( ) ____________

Email Address ______________________________

SS # ___–___–____ If full-time student, name of school ______________

Employer ______________ Occupation ______________

Martial Status: ________ Account Holder *(if other than patient)* ______________________________
First MI Last

Address ______________________________ Phone ( ) ____________
Street City Zip

In case of emergency, please contact ______________________________
Name Relationship Phone

Whom may we thank for referring you? ______________________________

Dental Insurance

Coverage by: ◯ Self ◯ Spouse ◯ Both ◯ Not Insured / Self-Pay

Insurance Info (Self)

Name ______________________________
First MI Last

SS # ___–___–____

Date of Birth ____________ Age ________
mm/dd/yy

Employed by ______________________________

Business Address ______________________________

Business Phone ( ) ____________

Insurance Co. ______________________________

Insurance Claims Mailing Address ______________________________

Toll-Free Phone # ( ) ____________

Group # ____________ Local # ____________ *(If Union)*

Insurance Info (Spouse)

Name ______________________________
First MI Last

SS # ___–___–____

Date of Birth ____________ Age ________
mm/dd/yy

Employed by ______________________________

Business Address ______________________________

Business Phone ( ) ____________

Insurance Co. ______________________________

Insurance Claims Mailing Address ______________________________

Toll-Free Phone # ( ) ____________

Group # ____________ Local # ____________ *(If Union)*