New Patient Registration

PATIENT INFORMATION:

First Name: _____ Last Name: _____
Birth date: _____ Sex: ☐ Male ☐ Female Marital Status: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ txt confirmation ☐
Email address: _____
Would you like to receive email correspondence? ☐ Yes ☐ No License #: _____

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: _____

GENERAL INFORMATION:

Whom may we thank for referring you to our office? _____
What is your favorite radio station? _____
In Case of an emergency who can we contact? _____
Relationship: _____ Phone number: _____

DENTAL HEALTH:

Dental reason for coming to our office (e.g. pain, cleaning, ect.): _____
Name of last dentist: _____
Address: _____ Phone: _____
Date of last treatment: _____ Reason for change: _____
Do you like your smile? O Yes O No
If no, how would you improve it? _____