

## NEW PATIENT REGISTRATION

Patient's Full Name (Last, First, MI): \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Sex: Male / Female Marital Status: \_\_\_\_\_  
Work Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_ Whom may we thank for referring you?  
Cell Phone: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

## PRIMARY DENTAL INSURANCE COVERAGE

Account-holder Name and Address: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

## SECONDARY DENTAL INSURANCE COVERAGE

Account-holder Name and Address: \_\_\_\_\_  
Relation to Patient: \_\_\_\_\_ SS#: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group/Plan #: \_\_\_\_\_

## EMERGENCY CONTACT/ PARTY RESPONSIBLE FOR PATIENT

Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_

