— Everyone's —
Family Dental

NEW PATIENT REGISTRATION

First Name: _____Last Name: _____

Preferred Name: _____ _____Date of Birth: _____

Address:_____

City: _____State: _____Zip Code: _____

Best Contact Number: _____Work Phone: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Other: _____

Email Address: _____ ☐ Yes, send me email alerts

Emergency Contact: _____Phone: _____

Previous Dentist and/or Dental Office: _____

How did you hear about us? ☐Live/work in the area ☐ Google ☐Yelp ☐ I was referred by:_____

☐Other: _____

Insurance Information (Policy Holder)

☐ ☐ ☐

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Date of Birth: _____

Member ID/SS#: _____ Group #: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐Parent ☐Child ☐Spouse ☐ Other: _____

Secondary Insurance Responsible Party (someone other than self is the Insurance Policy Holder)

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Date of Birth: _____

Member ID/SS#: _____ Group #: _____

Name of Employer: _____

Relationship to Insurance holder: ☐ Self ☐ Parent ☐ Child ☐Spouse ☐ Other: _____

Responsible Party :

Name of Person Responsible For this Account: _____

Relationship to Patient_____Email:_____

Phone Number: _____Driver's License # _____Date of Birth: _____

Employer:_____ Work Phone: _____ SS#/Sin_____

For your convenience, we off the following methods of payment. Please check the option you prefer. Payment in full required at each appointment. ☐ Cash ☐Personal Check ☐ Credit Card ☐ I wish to discuss the office payment policy