PATIENT REGISTRATION FORM

First Name ______________________________

Last Name ______________________________

Preferred Name ______________________________

Date of Birth ____________________ Patient YES ◯ NO ◯

Responsible Person ______________________________

Address ______________________________

City ____________________ State ____________ Zip ____________

Phone ____________________ SSN # ____________________

I would like to receive correspondences via email YES ◯ NO ◯

Email ______________________________

INSURANCE INFORMATION

Primary Insurance Name ______________________________

Policy Holder ____________________ ID # ____________

Group Name ____________________ Group Number ____________

Carrier Phone# ____________________ Effective Date ____________

Secondary Insurance Name ______________________________

Policy Holder ____________________ ID # ____________

Group Name ____________________ Group Number ____________

Carrier Phone# ____________________ Effective Date ____________

OFFICE PREFERENCES: Mark all that apply

EAST (Edgemoor) ◯ WEST (Central) ◯ DERBY ◯

DENTAL RECORDS

Previous Dentist ______________________________

How did you hear about our office ______________________________

ADDITIONAL INFORMATION

Emergency Contact Name ______________________________

Emergency Contact Phone number ______________________________

Name of your Employer ______________________________