New Patient Registration

Patient Information:

First Name:_____Last Name:_____ DOB:_____
Address:_____ City/State/Zip:_____
Social Security Number:_____ Drivers License:_____
Home Phone: _____ Cell Phone:_____ Work Phone:_____
Sex: O Male O Female Marital Status: O Married O Single O Divorced O Separated O Widowed
E-Mail: _____I would prefer to be contacted by: O E-Mail O Text
Employment Status: O Full time O Part time O Retired Student Status: O Full time O Part time
Medicaid ID: _____ Employer ID:_____ Carrier ID:_____
Previous Dentist:_____
Preferred Pharmacy (Include telephone number): _____
Emergency Contact: _____ Relation: _____ Phone Number: _____

How did you hear about our office: O Website O Mail/Valpak O Clifton Chronicle O Referral from Friend, if so, who? We would like to thank them: _____

Patient is: O Policy Holder O Responsible Party

O Responsible party is also a policy holder for patient O Primary insurance policy holder O Secondary insurance policy holder

Responsible Party Information:

First Name:_____Last Name:_____ DOB:_____
Address:_____ City/State/Zip:_____
Social Security Number:_____ Drivers License:_____

Primary Insurance Information:

Name of Insured: _____Relationship to Insured: O Self O Spouse O Child O Other
Insured Soc. Sec.: _____ Insured Birth Date: _____
Employer:_____ Employer Address: _____
Insurance Company:_____
Insurance Address: _____

Secondary Insurance Information:

Name of Insured: _____Relationship to Insured: O Self O Spouse O Child O Other
Insured Soc. Sec.: _____ Insured Birth Date: _____
Employer:_____ Employer Address: _____
Insurance Company:_____
Insurance Address: _____

I, _____, verify that the information given above is accurate as of (date): _____

Signature: _____Date: _____