New Patient Registration Information

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form as completely as you can. If you have questions we'll be glad to help you.

Name: ______________________ ______________ DOB: __________ SSN: __________

Last Name First Name Prefer to be called by

Drivers License #: __________________ Street Address: ______________________________

City: ______________________________ State: __________ Zip: __________

Billing Address (if different): ______________________________

City: ______________________________ State: __________ Zip: __________

Please provide all phone numbers and emails. Circle the number at which we can best reach you:

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Email Addresses: ______________________________

Employed by: __________________ Address: ______________________________

Business Email: ______________________________ Business Phone: __________

Best method of contact (check all that apply): ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Notify in case of emergency (local but not living with you): __________________ Phone: __________

Name of current dental insurance: ______________________________

Person responsible for account if other than yourself: ______________________________

Birthday of person responsible for account if other than patient: __________ SSN: __________

Signature: ______________________________ Date: __________

--**VERIFICATION OF BENEFITS** --

(For Office Use)

Insurance Provided By:	Group #:	ID#:		Date Info Requested:
Yearly Plan Max:	Annual Deductible:		Family Deductible:	
Class 1-Prev:		# of Prophy/yr:		Perio:
Class 2-Basic:	Post. Comp:	# of Exams/yr:		BWX/yr:
Class 3-Major:		Frequency FMX:		Pano:
SRP on file:		Date of last FMX:		Pano:
Fluoride Tx: /yrs	To Age:	Night Guard:		
Sealants:	To age:	Which Teeth:		
Implants:	Ortho:			To Age:
Claims Address		Fax #:		Ins information received via:
Payer ID:	Spoke with:			Initial:
Secondary Insurance:	Policy Holder:		ID#:	Group #: