PATIENT REGISTRATION

Date:

Name: _____ Is there a nickname you prefer? _____

Birthdate: _____ Social Security #: _____ Driver's License #: _____

Home #: _____ Cell #: _____Work#: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Preferred Contact: **Home / Cell / Work / Email**

Emergency Contact: _____ Emer. Phone #: _____ Relationship: _____

INSURANCE INFORMATION

☐ **Are you covered by Dental Insurance?** If yes, Insurance Carrier: _____

Name of Insured: _____ Social Security #: _____ Birthdate: _____

Group Name: _____ Group#: _____ Insurance Phone #: _____

☐ **Are you covered by a Secondary Dental Insurance?** If yes, Insurance Carrier: _____

Name of Insured: _____ Social Security #: _____ Birthdate: _____

Group Name: _____ Group#: _____ Insurance Phone #: _____

PATIENT DETAILS

How did you hear about us? ☐ Facebook ☐ Yelp ☐ Google ☐ Friend/Family: _____

☐ Walking By ☐ Other: _____

What would you like to see improve or change about your smile? *(Check all that apply)*

☐ Straighter ☐ Whiter ☐ Repair Broken Teeth ☐ Replace Teeth ☐ Replace Silver (Mercury) Fillings

FAMILY MEMBERS BELONGING ON ACCOUNT

Name:_____ DOB:_____ Name:_____ DOB:_____

Name:_____ DOB:_____ Name:_____ DOB:_____

I authorize The Dental Center to use this information for treatment, payment, and other necessary communication for my dental care.

Patient Signature (or Guardian): _____ Date: _____