FAMILY PATIENT REGISTRATION for DENTAL HEALTH CLINIC

Family Member's Information:

First: _____ MI: _____ Last: _____ Preferred Name: _____
Birth Date: _____ SS#: _____ Sex: ○ Male ○ Female

First: _____ MI: _____ Last: _____ Preferred Name: _____
Birth Date: _____ SS#: _____ Sex: ○ Male ○ Female

First: _____ MI: _____ Last: _____ Preferred Name: _____
Birth Date: _____ SS#: _____ Sex: ○ Male ○ Female

First: _____ MI: _____ Last: _____ Preferred Name: _____
Birth Date: _____ SS#: _____ Sex: ○ Male ○ Female

First: _____ MI: _____ Last: _____ Preferred Name: _____
Birth Date: _____ SS#: _____ Sex: ○ Male ○ Female

EMERGENCY CONTACT: _____ RELATIONSHIP: _____
CONTACT PHONE: _____

How did you hear about our office? Online/Phone Book/Referral/Previous Patient/Child of patient

Responsible Party

First Name: _____ MI: _____ Last Name: _____
Address: _____
City, State, Zip: _____
Home/Cell Phone: _____ May we contact you by text? ○ Yes ○ No
Email: _____ May we contact you by email? ○ Yes ○ No
Relationship to Patient: ○ Parent ○ Guardian ○ Other: _____
Birth Date: _____ SS#: _____
Employer_____ Work Phone: _____

Dental Insurance Policy Holder Information: Dental Insurance? ○ YES, please fill out ○ NO, skip this section

○ Policy Holder is Responsible party, skip this section.

Policy Holder First Name: _____ MI: _____Last: _____
Employer (if policy is a group policy): _____Work Phone: _____
Address: _____ City, State, Zip: _____
Phone Number: _____Patient's relationship to Insured: ○Self ○Spouse ○Child ○Other
Birth Date: _____ SS#: _____ ID#:_____

To File any insurance, we need the physical card presented due to the many different policies and claim addresses. Please provide the physical front & back of your dental insurance card

Thank you for taking the time to fill this out in its entirety!