# MY FAMILY DENTAL

## Patient Registration Form

Today's Date:

Title: Dr. Mr. Mrs. Ms. Miss

First Name: ____________ Middle: ____________ Last: ____________

Street: ____________ City: ____________ State: ________ ZIP: ________

Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________

Email Address: ____________

May we contact you by email? YES NO May we contact you by text? YES NO

Sex: M F Date of Birth: ____________ Social Security #: ____________

Marital Status: S M D Spouse's Name: ____________

Whom may we thank for referring you? ____________

How did you hear about us? Please circle / check all that apply:

Mailer Google Friends/Family Insurance Internet Yellow Pages Other: ____________

INSURANCE INFORMATION: Do you have Dental Insurance? Yes No

### PRIMARY INSURANCE

Subscriber Name: ____________ Employer Name: ____________

Subscriber ID/SSN: ____________ Employer Phone #: ____________

Date of Birth: ____________ Insurance Company: ____________

Relation to Subscriber: Self Spouse Child Other Insurance Group #: ____________

Insurance Phone #: ____________

### SECONDARY INSURANCE

Subscriber Name: ____________ Employer Name: ____________

Subscriber ID/SSN: ____________ Employer Phone #: ____________

Date of Birth: ____________ Insurance Company: ____________

Relation to Subscriber: Self Spouse Child Other Insurance Group #: ____________

Insurance Phone #: ____________

Please present your Insurance Card/s and Driver's License to the business team to be scanned.

I, hereby by virtue of my signature below, give my consent to allow this office and staff to leave messages and speak to person(s) listed regarding scheduling, treatment, and financials or other information as necessary.

Name: ____________ Relationship: ____________

Name: ____________ Relationship: ____________

Name: ____________ Relationship: ____________

If the patient is under the care of a facility and it is listed, consent will apply for all staff of the facility.

__ I do consent to messages being left at home, work, mobile phone, or with any other person.

__ I do not consent to a message being left at home, work, mobile phone, or with any other person.

I, hereby by virtue of my signature below, attest that all information provided on this "Patient Registration Form" is correct.

First & Last Name: ____________ Birthdate: ________

Signature: ____________ Date: ________