CONTEMPORARY DENTISTRY AND IMPLANTOLOGY
NEW PATIENT REGISTRATION

PATIENT INFORMATION (CONFIDENTIAL)

Name:		Date:
Date of birth:	SSN:	
Current address:		
City:	State:	ZIP Code:
Email address:		
Home Phone:	Cell Phone:	Work Phone:
Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated		
If College Student: Fulltime Part-time	Name of School:	
School City:	School State:	
Patient's or Parent/Guardian's Employer:		Work Phone:
Employer's Address:		
City:	State:	ZIP Code:
Spouse or Parent/Guardian's Name:		
Employer:		Work Phone:
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:

RESPONSIBLE PARTY

Name of person responsible for this account:		Relationship to patient:
Address:		Home phone:
Driver's License #:	Birthdate:	SSN:
Employer:		Work phone:
Is this person currently a patient in our office?		

INSURANCE INFORMATION

Name of insured:		Relationship to patient:
Birthdate:	SSN:	Date employed:
Employer:	Union or Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?

NEW PATIENT REGISTRATION

Do you have any additional insurance? Yes No If yes, complete the following:

ADDITIONAL INSURANCE INFORMATION

Name of insured:		Relationship to patient:
Birthdate:	SSN:	Date employed:
Employer:	Union for Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?

SIGNATURES

Signature of patient or parent/guardian if minor.	Date: