NEW PATIENT REGISTRATION **Adults**

We are pleased to welcome you to our dental practice. We promise to do our best to provide you with the finest care available. Please take a few minutes to fill out this ***confidential*** *form as best as you can.*

Patient's name _____ Date of Birth _____

Home Address _____ Phone # _____

_____ Cell Phone _____
city state zip

Purpose of this appointment_____

Whom may we thank for referring you to our office?_____

In the event of an emergency, whom should we contact?_____

Relationship to you_____ Phone #'s_____ _____

Personal Information

Social Security #_____ Spouses S. S. #_____

Marital status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Name of spouse _____ Date of Birth_____

If a child, parents names _____ _____

Names of children _____ _____ _____ _____

Employment Information

Patient employed by_____ Phone #_____

Present position_____ How long_____

Business Address_____
street city state zip

Spouse employed by_____ Phone #_____

Present position_____ How long_____

Business Address_____
street city state zip

Financial Information

Person responsible for this account_____ Do you have any Dental Insurance? ☐ Yes ☐ No

☐ If you have a Secondary Insurance please inform our front desk

The cost for dental care is a patient's responsibility and overdue balances with our office will be assessed Finance Charges of 1.5% monthly with a minimum of $4.00. Remember, dental insurance is a patient's benefit to help with some of the costs of dental care. We will help you in receiving and maximizing **<u>your</u>** benefits, but insurance does not dictate treatment. We will diagnose and treatment plan only in the best interests of each patient.

_____ _____
Signed Date