New Baltimore Family Dentistry

Patient Registration

DATE: _____

PATIENT INFORMATION

First Name		**MI**		**Last Name**			
Birth Date		**Social Security #**		**Gender**	❑ Male	❑ Female	
Marital Status	❑ Minor	❑ Married	❑ Single	❑ Divorced	❑ Separated	❑ Widowed	
Address							
City		**State**		**Zip Code**			
Home Phone		**Work Phone**	Ext.	**Cell Phone**			
Email Address		❑ I would like to receive correspondences via e-mail.					
Employment Status	❑ Full Time	❑ Part Time	❑ Retired	**Student Status**	❑ Full Time	❑ Part Time	❑ N/A
Whom may we thank for referring you?							

RESPONSIBLE PARTY - Please complete this section if responsible party is someone other than the patient

First Name		**Last Name**		**Birth Date**			
Address		**City**		**State**		**Zip Code**	
Home Phone		**Work Phone**	Ext.	**Cell Phone**			
Social Security #		**Driver's License #**		**Employer**			
Relationship to Patient		**Is this person currently a patient in our office?**		❑ Yes	❑ No		

PRIMARY INSURANCE INFORMATION

Name of Insured	FIRST	MI	LAST		
Relationship to Insured	❑ Self	❑ Spouse	❑ Child	❑ Other	**Birth Date**
Insurance ID #		**Group #**			
Employer		**Insurance Co.**			
Address		**Ins. Address**			
City, State, ZIP		**City, State, ZIP**			

SECONDARY INSURANCE INFORMATION

Name of Insured	FIRST	MI	LAST		
Relationship to Insured	❑ Self	❑ Spouse	❑ Child	❑ Other	**Birth Date**
Insurance ID #		**Group #**			
Employer		**Insurance Co.**			
Address		**Ins. Address**			
City, State, ZIP		**City, State, ZIP**			

EMERGENCY CONTACT INFORMATION

Emergency Contact	FIRST	MI	LAST	
Relationship to Patient		**Phone #**		

New Baltimore Family Dentistry
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