

Patient Registration Information



Gove
FAMILY DENTISTRY

Date _____

Name _____
Last First M Preferred

Address _____ City _____ State _____ Zip _____

E-Mail _____ Birthdate _____

Home Phone _____ Work Phone _____ Cell Phone _____

How would you like for us to contact you? ☐ Phone ☐ Text ☐ Email

Drivers License # _____ Social Security # _____

Are You: ☐ Minor ☐ Single ☐ Married ☐ Other _____
☐ Male ☐ Female

Employer (Parent's employer if minor) _____ Work Phone _____

Occupation _____ Spouse's name (Parent's name if minor) _____

Spouse's Birthdate _____ Work Phone _____

Emergency contact other than spouse or parent _____ Phone _____

Whom may we thank for referring you? _____

What did you like or dislike about your previous dental office? _____

Responsible Party

_____ Check if same as above

Person responsible for this account _____ Relationship _____

Address _____ Home Phone _____

City, State, Zip _____

Insurance Information

Name of policyholder _____

Relationship to patient _____

Birthdate _____ Insurance ID # _____ SSN: _____

Address if different from above _____

Insurance Company _____ Phone # _____

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

Name of policyholder _____

Relationship to patient _____

Birthdate _____ Insurance ID # _____ SSN: _____

Address if different from above _____

Insurance Company _____ Phone # _____