MINT TO BE FAMILY DENTISTRY · PATIENT REGISTRATION INFORMATION

Patient Name: _____ Birthdate: _____
Last First Middle

Preferred Name: _____ Social Security: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____ Preferred Language: _____

Preferred E-mail Address: _____ Appointment Reminders: ◯ Text ◯ E-mail

Employer: _____ Occupation: _____

Do you have dental insurance? ◯ Yes ◯ No Are you the policy holder? ◯ Yes ◯ No

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

RESPONSIBLE PARTY INFORMATION

If information is same as above, please mark circle to the right and skip to next section. ◯

Name: _____ Birthdate: _____
Last First Middle

Social Security: _____ Relationship to Patient: _____

Address: _____
Street City State Zip

Cell Phone: _____ Home Phone: _____Work Phone: _____

Preferred E-mail: _____ Employer: _____ Occupation: _____

Do you have dental insurance? ◯ Yes ◯ No Are you the policy holder? ◯ Yes ◯ No

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Security: _____
Last First Middle

Insurance Company: _____

Group #: _____ Subscriber ID #: _____

Insurance Co. Address: _____ Phone No.: _____

EMERGENCY INFORMATION

Name/Relationship to Patient: _____
Last First Middle

Address: _____
Street City Zip

Phone(s): _____

_____
Signature of Patient, Guardian, and/or Responsible Party Date Relationship to Patient