Prima Smile Dental
베이사이드 가족치과

New Patient Registration Form

What is your reason for visiting us today? _____

How did you hear about us?

[ ] Google [ ] Social Media [ ] Newspaper Ad [ ] Referal by _____ [ ] Other _____

PATIENT INFORMATION

Name: _____ Birthdate __/__/____ Phone (___)_____

Address: _____City:_____ State_____ZIP _____

Sex _____ Status (Circle one): Single / Married / Minor

E-mail: _____ Alt#1 (___)_____ Alt #2 (___)_____

Employer/School: _____ Employer/School Phone (___)_____

Employer/School Address:_____ City:_____ State _____ ZIP_____

Spouse or Parent Name:_____

Person to contact in case of an emergency?_____ Phone (___)_____

RESPONSIBLE PARTY

Name of Person:_____

Responsible for this account: _____ Relation to Patient:_____

Phone (___)_____ Address (If living separately):_____

Driver license #:_____ Birthdate __/__/____ Work Phone: (___)_____

Employer:_____

Currently a patient in our office? (Circle one) Y/N E-mail:_____

INSURANCE INFORMATION

Health Insurance Company: _____

Primary Holder: _____ Birthdate__/__/____

Relation to Patient:_____

Member ID: _____ or Social Security #: _____

Group Number: _____