

## New Patient Registration

**Note: All information must be as it appears on your dental insurance website:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth # \_\_\_\_\_

**How did you hear about our office?**

Referred by: \_\_\_\_\_

**If you are you the policy holder, please provide the following:**

Employer name: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Member I.D: \_\_\_\_\_  
Group #: \_\_\_\_\_  
SSN # \_\_\_\_\_

**If you are listed as a beneficiary on someone else's policy, please provide the following:**

Name of policy holder \_\_\_\_\_  
Address \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Date of Birth # \_\_\_\_\_  
Employer's name: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_  
Member I.D: \_\_\_\_\_  
Group #: \_\_\_\_\_  
SSN # \_\_\_\_\_