Baechtold
FAMILY DENTISTRY

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New Patient Registration Form

Today's Date: _____
Have you ever been a patient with us before? _____
If so, when? _____

PLEASE GIVE COPY OF INSURANCE, ID, X-RAYS AND/OR REFERRAL SLIP TO RECEPTIONIST

PATIENT INFORMATION

Name _____
Parent or Guardian (if child) _____
Spouse (if married) _____
Mailing address _____
City _____ State _____ ZIP _____
Home Phone _____
Work Phone _____
Cell Phone _____
College (if student) _____
Full time or Part time _____

Preferred Name _____
Marital Status: S ☐ M ☐ D ☐ W ☐
Birth Date _____ Age _____ Sex _____
Social Security # _____
Occupation _____
Employer _____
Address _____
City _____ State _____ ZIP _____
Dentist's Name _____
Physician's Name _____

BILLING INFORMATION (In whose name should the account be listed?)

Individual or Shared/Family Account: _____
Name _____
Address _____
City _____ State _____ ZIP _____
Home Phone _____
Work Phone _____
Do you have insurance that you would like us to file for you? Yes ☐ No ☐

Relationship to Patient
Occupation
Employer _____
Address _____
City _____ State _____ ZIP _____

INSURANCE INFORMATION (Primary)

Policy Holder's Name _____
Insurance Company _____
Address _____
City _____ State _____ ZIP _____
Social Security # _____
Policy Certificate or ID# _____

Type (check one) Medical ☐ Dental ☐
Employer _____
Address _____
City _____ State _____ ZIP _____
Birth Date _____
Group # _____

INSURANCE INFORMATION (Secondary)

Policy Holder's Name _____
Insurance Company _____
Address _____
City _____ State _____ ZIP _____
Social Security # _____
Policy Certificate or ID# _____

Type (check one) Medical ☐ Dental ☐
Employer _____
Address _____
City _____ State _____ ZIP _____
Birth Date _____
Group # _____

ADDITIONAL INFORMATION

Have we seen any of your family or friends?
Who Referred You?
EMERGENCY CONTACT:
Name _____
Address _____
City _____ State _____ ZIP _____
Phone _____

Please name them _____
Reason for this visit _____
Nearest living relative (not living with you) _____
Name _____
Address _____
City _____ State _____ ZIP _____
Phone _____