ELEVATE
FAMILY DENTISTRY

PATIENT REGISTRATION

Today's Date _____

Patient Name _____ Date of Birth _____

Social Security # _____ M ____ F ____

Address: _____ City, State, Zip _____

Home # _____ Cell # _____ Email _____

How do you prefer to be contacted? (circle all that apply): Call (home/cell) Email Text Message

How did you hear about our office? (if from an existing patient please list their name) _____

Are any members of your family current patients with us? (list names) _____

_____

Name of Previous Dentist _____ Phone # _____

Person responsible for account if different than patient _____Relation _____

Emergency Contact Name _____ Phone # _____

INSURANCE

Primary Coverage

Subscriber's Name _____ Date of Birth _____ Member ID # _____

Employer _____ Group/Plan Name _____ Group/Plan # _____

Insurance Company _____ Phone # _____

Secondary Coverage

Subscriber's Name _____ Date of Birth _____ Member ID # _____

Employer _____ Group/Plan Name _____ Group/Plan # _____

Insurance Company _____ Phone # _____

Patient Signature _____ **Date** _____