NEW PATIENT REGISTRATION

Patient: _____ Preferred Name: _____
Last Name First Name Middle Initial

Home #: _____ Work #: _____ Cell # :_____

Email Address: _____

The best way to contact me is through: □ Text □ Email □ Cell □ Home □ Work □ No preference

Home Address: _____

City: _____ State: _____ Zip: _____

DOB: _____/_____ /_____ Social Security #:_____ □ Male □ Female / □ Single □ Married
MM DD YYYY

Employer: _____ Spouse Name: _____ Spouse's Employer:_____

Alternate Contact (Outside of Home/Spouse): _____

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

PERSON RESPONSIBLE FOR ACCOUNT: _____ Address: _____

Method of Payment (After Insurance Payments): □ Cash/Check □ Credit Card □ Third Party Financing

PRIMARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID# _____

SECONDARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID # _____

MEDICAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID # _____

I authorize treatment by Dr. Birch, Dr. Ostteen, and Dr. Cramer and agree to pay all related professional fees. Fees not covered by my dental/medical insurance will be promptly paid upon notification from this office. I have received a copy of the office's financial policy, and without I agree to abide by the policies outlined therein.

Signature: _____ Date: _____