# New Patient Registration Form

1st Family Dental
www.1fd.org

**Referral Source**: ______________________________________________________________

*Our forms are printed on paper sourced from sustainable forests. Soon we will become a paperless practice!*
*Help support our* ***Green Initiative*** *by providing your email address to receive statements and reminders digitally.*

## SECTION I: Patient Information

***Email:** ____________________________________________ ☐ Yes! Please send me email appointment reminders
Name (Last, First): _____________________________________ I prefer to be called: ________________________
Date of Birth: ____/____/______ Soc. Sec. # : ________________ StateID/License#:___________________________
Address (Line 1): ____________________________ Address (Line 2): ___________________________
City: ___________________________ State:______ Zip Code: __________
Cell Phone: (______)_____________ Home Phone: (______)_____________ Work Phone: (______)____________
The best time to contact me is _____________ ☐ AM ☐ PM on my ☐ Cell # ☐ Home # ☐ Work #
Check appropriate box: ☐ Minor ☐ Single ☐ Married/Partner ☐ Separated/Divorced ☐ Widowed
Employment Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Other/Not Applicable If you are a student: ☐ FT ☐ PT
Emergency Contact: (Name) __________________________ (Phone #) _______________________

## Section II: Responsible Party Information

(If someone other than patient, and/or patient is under age 18)

***Email:** ___________________________________ ☐ Yes! Please send me appointment reminders via email
Relationship to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other: __________________________
Name (Last, First): ______________________________________________________________________________
Address (Line 1): _________________________ Address (Line 2): ____________________________________
City: ___________________________ State:______ Zip Code: _______________
Date of Birth: ____/____/______ Soc. Sec. # : ________________ StateID/License#:___________________________
Cell Phone: (_____)_____________ Home Phone: (______)_____________ Work Phone: (______)____________
The best time to contact me is ______________ ☐ AM ☐ PM on my ☐ Cell # ☐ Home # ☐ Work #

## Section III: Insurance Information

Name of Insured: _______________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other
Insured's Soc. Sec. #: ___________________ Insured's Date of Birth: __________________
Employer: __________________ Employer Address: __________________________________________________
Insurance Provider: ________________________ Group #: _____________________ ID #: _____________________

---- (Please complete below if you have any additional Insurance) ----

Name of Insured: _______________________ Relationship to Patient: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________
Insured's Soc. Sec. #: _________________________ Insured's Date of Birth: __________________
Employer: __________________ Employer Address: __________________________________________________
Insurance Provider: _____________________ Group #: ______________________ ID #: _______________________

Additional Comments: