1051 S State Rd 7, Suite 1
Wellington, FL, 33414
Phone - (561) 790-0206, Fax - (561) 795-5445

Patient Registration

*(* denotes required)*

Personal Information

First Name*

Middle Initial

Last Name*

Date of Birth*

Gender*

- [ ] Female
- [ ] Male

Social Security Number

(Used for insurance purposes)

Street Address*

Street Address (cont.)

City*

State*

Zip Code*

Contact Preferences

Email Address*

Mobile Phone Number*

Home Phone Number

Emergency Contact

First Name

Last Name

Phone Number

Relationship to patient:

Additional People on this Account

Person Responsible for Account (if different from patient)

(First and last name of the responsible party)

Phone Number of Responsible Party (if different from patient)

Relationship to Patient

- [ ] Father
- [ ] Mother
- [ ] Spouse
- [ ] Other

Dental Insurance

Policy Holder’s First Name

Policy Holder’s Last Name

Policy Holder's Date of Birth

Name of Insurance Company

Policy Number/Member Number/Subscriber ID

Group Number

Name of Employer

Insurance Company Phone Number

Do you have a secondary dental insurance policy?

(If yes, please provide secondary dental insurance information to an office team member.)

- [ ] YES
- [ ] NO

How did you hear about our office? (insurance, facebook, instagram, current patient, google, other)

Patient Signature