Water's Edge Dentistry

New Patient Registration

Last Name, First Name _____ **Middle Initial** _____

Nickname _____ **SSN(required)**_____ **Birthdate** _____

Gender: Male / Female **Marital Status:** Single / Married / Divorced / Separated / Widowed

Military: Yes / No **Retired?** Yes / No

Address_____

City _____**State** _____ **Zip Code** _____

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Preferred Contact Method (please check all that apply): Cell Phone ☐ **Home Phone** ☐ **Work Phone** ☐

Email Address _____**(Appointment Reminders)**

Employer _____**Occupation** _____

Guardian/Parent Name (if patient is under 18)_____

Guardian/Parent SSN _____**Guardian/Parent Birthdate** _____

Spouse's Employer _____**Spouse's Work Phone** _____

Emergency Contact _____**Emergency Contact Phone** _____

How did you hear about Water's Edge Dentistry? _____

Insurance Information

Primary Insurance _____ **Policy Holders Name** _____

Policy Holder's SSN (required)_____ **Policy Holder's Birthdate** _____

Policy Holder's Employer_____ **Employer Phone** _____

Policy ID # _____ **Policy Group #** _____

Secondary Insurance _____ **Policy Holders Name**_____

Policy Holder's SSN (required)_____ **Policy Holder's Birthdate** _____

Policy Holder's Employer_____ **Employer Phone** _____

Policy ID # _____ **Policy Group #** _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE FRONT DESK

I hereby authorize the physician to provide information to insurance carriers concerning my dental care and I hereby irrevocably assign to the doctor all payments for all the services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken as part of my plan of treatment and confidential patient record.

Signature of Patient or Parent/Guardian: _____**Date:**_____