

New Patient Registration Form

Please complete all fields. Bring this form to your first appointment.

Personal Information

Last Name: _____

First Name: _____

Date of Birth: _____

Gender: _____

Phone: _____

Email: _____

Address: _____

City: _____

State: _____

ZIP Code: _____

Social Security (optional):

Driver's License #: _____

Emergency Contact

Contact Name: _____

Relationship: _____

Phone: _____

Alt. Phone: _____

Dental Insurance Information

Insurance Company:

Policy/ID Number: _____

Group Number: _____

Subscriber Name: _____

Subscriber DOB: _____

Subscriber Employer:

Subscriber Phone: _____

Relationship to Patient:

I have secondary dental insurance

Secondary Insurance:

Secondary ID #: _____

Payment Preferences

We accept most dental insurance (PPO, HMO, Medi-Cal/Denti-Cal), CareCredit, Alpheon, Sunbit, Cherry, cash, and all major credit cards.

- Insurance
- Medi-Cal / Denti-Cal
- CareCredit / Financing
- Self-Pay / Cash

How Did You Hear About Us?

- Google Search
- Friend / Family Referral
- Insurance Directory
- Social Media
- Drive-by / Walk-in
- Other: _____

Patient/Guardian Signature:

Date: _____
