



### Patient Registration Form

Thank you for selecting our dental health team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us. We will be happy to help.

**Information of Individual Completing Form:**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Marital Status (Circle One): S M D W Gender (Circle One): M F  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
 Relationship to patient \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Additional Family Members on Account:**

	Spouse	First Child	Second Child	Third Child
Last Name				
First Name				
Birthdate	____/____/____	____/____/____	____/____/____	____/____/____
Medicaid #				
SS#				

**Appointment Confirmation & Reminders:**

Cell Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

**How did you hear about us?**

Internet \_\_\_ Phone Book \_\_\_ Newspaper \_\_\_ Patient \_\_\_ Other \_\_\_\_\_

**Primary Dental Insurance Information:**

Subscriber Name: \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Subscriber's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dental Insurance Name: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_

Do you have secondary dental insurance coverage? (Circle one) Yes No

**Secondary Dental Coverage:**

Subscriber Name: \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Subscriber's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Dental Insurance Name: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_

**Missed or Failed Appointment Policy:**

House Family Dental is careful in scheduling each appointment so that each patient receives their recommended treatment in a reasonable amount of time while still accommodating individual needs. In order to consistently provide this type of care, it is important for our patients to be on time for their scheduled appointments so we can keep our schedule running smoothly. Based upon this practice philosophy, we have adopted a policy regarding no-show or last minute cancellations. Once you have missed 3 appointments, you will only be allowed to make a same-day-only appointment. A same-day appointment will require you to call our office on the day you are available and we will fit you in if there is availability. In addition, we understand the busy lives of our families and offer family appointments to better accommodate your needs. However, if a family appointment is missed, we will only be able to accommodate you on an individual basis in the future. If you move or change phone numbers without informing our office, we may be unable to contact you in order to confirm an appointment. In such an instance, your appointment time will not be held for you.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date