HOUSE DMD
FAMILY DENTAL

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.

Person Responsible for Account (if different than patient) Name: _____

Relationship to patient(s): _____ SS#: _____ Date of Birth: _____

Patient Information - 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: (_____) _____

Employer Name:_____ Email: _____

Who may we thank for referring you to our office? _____

Additional Family Members on Account:

1.Name: _____ Relationship to patient: _____ DOB _____

2.Name: _____ Relationship to patient: _____ DOB _____

3.Name: _____ Relationship to patient: _____ DOB _____

Children under 16 must be accompanied by a parent/legal guardian. 16 to 18 year old's must have parent/guardian's written consent for treatment

PRIMARY DENTAL INSURANCE INFORMATION:

Subscriber Name: _____ Relationship to patient: _____

Subscriber's Address (if different than patient): _____

Subscriber's SS#: _____-_____-_____ Date of Birth: _____ Phone: _____

Dental Insurance Company: _____

Subscriber ID#: _____ Group #: _____

Employer Name: _____

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

Secondary Dental Insurance Information:

Subscriber Name: _____ Relationship to patient: _____

Subscriber's SS#::_____-_____-_____ Date of Birth: _____ Phone: _____

Dental Insurance Company: _____

Subscriber ID#: _____ Group #: _____

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 Patient or Parent/Legal Guardian Date