New Patient Registration Form – Please tell us about yourself

Name: _____ ☐ Male ☐ Female
Title First Last MI

Preferred Name: _____

Street Address: _____ City: _____ State _____ Zip: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

Employer (School): _____ Occupation (Grade): _____

Emergency Contact: _____ Emergency Contact Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Domestic Partner

How did you hear about our office: _____
If referred, please list who we may thank for referring you

How do you prefer to be contacted for appointment confirmation (ok to select more than one)? ☐ E-Mail ☐ Phone ☐ Text Message

INSURANCE – PRIMARY

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Phone: _____ Group Number: _____

INSURANCE – SECONDARY

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name: _____

Insurance Company Phone: _____ Group Number: _____

ASSIGNMENT & RELEASE

I hereby authorize Chagrin Highlands Dental Group to release all information contained in this form that is necessary to secure the payment of benefits from and any all insurance companies associated with my account.

Responsible Party Signature: _____ Date: _____