NEW ERA
FAMILY & COSMETIC DENTISTRY

Registration Form

(Please Print)

Today's Date _____

Patient Information

Patient Name _____ Marital Status (circle one)
Last name **First name** MI (**Preferred Name**) Single / Mar / Div / Sep / Wid

Birth date: / / Age: _____ Sex: □M □F Home Phone no.: _____

Street address: _____ City: _____ Zip _____

Social Security #:_____ Occupation: _____ Employer: _____

How did you hear about our office? : □ Dr. _____ □ Insurance Plan □ Family _____

□Friend _____ □ Drive By □ Google/ Internet □ Other

Other patients seen here: _____

Insurance Information

(Please give your insurance card to receptionist)

Person responsible for bill: _____ Birth Date: / / Address (if different) _____

Is this person a patient here: □Y □ N Occupation: _____ Employer: _____

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Employer Address: _____ Employer Phone no: _____

Please indicate primary insurance: _____ Group #: _____

Subscribers name: _____ Subscribers SS no#: _____ Birth Date: / /

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other

Name of Secondary insurance (if applicable): _____ Subscribers name: _____

Group #: _____ Patient relationship to subscriber: □ Self □ Spouse □ Child □ Other

In Case of Emergency

Name of local friend or relative (not living with you): _____ Relationship to you: _____

Phone no: _____ Work no: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize New Era Dentistry or insurance to release any information required to process my claims.

_____ _____
Patient/ Guardian Signature Date