New Patient Registration

Patient Name:_____ Preferred Name:_____

Male___ Female___ Married____ Single____ Child____ Other____

Birth date:_____ Social Security #:_____ Home Phone:_____

Cell Phone:_____ Email:_____

Home Address:_____
Full Street Address City State Zip

Employer:_____ Work Phone #:_____

Responsible party for account:_____

Emergency Contact: Name:_____ Phone #:_____

Please list other members of your immediate family who are patients in our office:_____

Referral Information

How did you hear about us?:_____ Name of Referral:_____

Insurance Information

Dental Insurance Company:_____ Name of policy holder:_____

Policy Holder's Address:_____

Policy Holder's Employer:_____ Is insured a patient? Yes_____ No_____

Policy Holder's Birthdate:_____ Phone:_____ ID#:_____ SSN#:_____

Patient's relationship to the insured:_____ Secondary Insurance? Yes____ No____

I, the undersigned, understand that dental insurance does not always cover all treatment costs. I understand that I am responsible for payment of all costs, including any portion of treatment not paid by insurance. I hereby authorize payment directly to Comfort Care Dental of any benefits otherwise payable. I understand Comfort Care Dental DOES NOT bill MCNA/Idaho Medicaid for dental services done in their office.

_____ _____

Signature of Patient(Parent/Guardian if Patient is a minor) **Date**

_____

Print Parent/Guardian Name