NEW PATIENT REGISTRATION

Welcome!

Thank you for choosing Raleigh Park Dental Care.
We are committed to providing every adult and child with the highest quality oral healthcare in the most gentle, efficient manner possible. Remember, the more we know about you, the better we can help you reach and maintain your goals.
Instructions: Please complete these Registration forms to the best of your knowledge. Then bring the completed and signed forms with you on your next appointment. Or, visit us at www.rpdentalcare.com to complete them online.
Thank you!

YOU MAY WANT TO MAKE COPIES OF THESE FORMS FOR YOUR FILES.

PATIENT INFORMATION

Patient's Name _____
Last First Initial

Preferred Name _____

Date of Birth _____

Parent's/Guardian's Name (if child under age 18):

_____
Last First Initial

Which of the following describe(s) your current status?

☐ Single ☐ Married ☐ Separated
☐ Divorced ☐ Widowed ☐ Minor

Home Address/PO Box _____

City _____ State _____ Zip _____

Phone #1: ( ) _____

Phone #2: ( ) _____

Email Address _____

Work Address/PO Box _____

City _____ State _____ Zip _____

Phone: ( ) _____ Ext.# _____

Patient/Parent Employed by _____

Present Position _____ How long held _____

Spouse/Parent Name _____

Spouse Employed by _____

Present Position _____ How long held _____

Responsible Party for this account _____

Responsible Party Social Security # _____

Method of Payment: ☐ Ins. Co-payment ☐ Credit Card ☐ Cash

Purpose of this visit _____

Other family members who are patients here:

_____

_____

DENTAL INSURANCE 1st COVERAGE

Employee Name _____

Date of Birth _____ Social Security # _____

Employer _____

Insurance Company Name _____

Address _____

_____

_____

Telephone ( ) _____

Group # _____

DENTAL INSURANCE 2nd COVERAGE

Employee Name _____

Date of Birth _____ Social Security # _____

Employer _____

Insurance Company Name _____

Address _____

_____

_____

Telephone ( ) _____

Group # _____

Whom may we thank for this referral? _____

In case of emergency, please notify:

Closest family member (Name/Phone):

_____

_____

Family or friend not living in same house (Name/Phone):

_____

_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____
Patient's Signature (or Responsible Person, if patient is a minor) Date