EISSENS DENTISTRY

New Patient Registration

Thank you for choosing Eissens Dentistry to partner in your dental care. We strive to provide exemplary dental care in a relaxing environment and look forward to getting to know you. Please complete the information below:

How did you hear about Eissens Dentistry? Friend/Family

Other: _____

Patient's Information:

First Name _____Last Name _____ MI ___ Date _____
Street Address _____ Home Phone _____
City, State and Zip _____ Work Phone _____
Email Address _____Cell Phone _____
Birth Date _____ Age _____ SSN#_____
Sex: ○Male ○Female Marital Status: ○Married ○Single ○Divorced ○Separated ○Widowed
Employer Name: _____ Employer Address:_____
Student: ○ Full-Time ○ Part-Time School Name _____
Emergency contact _____Emerg. Contact's #_____
Preferred Pharmacy _____ Pharmacy # _____

Responsible Individual (If other than patient)

First Name _____Last Name _____ MI____
Street Address _____Home Phone _____
City, State and Zip _____Work Phone _____
Birth Date _____ SSN# _____ Relationship to patient_____
Employer Name _____Employer Address _____

Primary Insurance Information (if applicable):

Policy Holder's Name_____ Relationship to Patient_____
Policy Holder Birth Date _____Age _____SSN#_____
Employer Name and Address _____
Insurance Company _____Group # _____

NOTE: ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT-NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE PAYMENT. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE.

I hereby authorize payment directly to Eissens Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all fees for professional services that are rendered. The information on this page is correct to the best of my knowledge.

Signature of Patient/Responsible Party _____Date _____