MT. Baldy Dental Center

Patient Registration

Patient First Name: _____ Last Name:_____ Middle Initial:_____

Preferred Name:_____

Name of Responsible Party:_____

Are we working with insurance? If so, who is the company? _____

Please provide your insurance cards to the front desk.

Billing Address:_____ Address 2:_____

City,State,Zip:_____

Seasonal/Other Address:_____

Cell Phone:_____ OK to send communication via text message:_____ *Yes_____ No

*By selecting yes you are authorizing for potential personal health information (PHI) to be sent via text message (limited circumstances).

Work Phone:_____ Ext:_____ Home Phone:_____

Email:_____ OK to send communication via email:_____ *Yes_____ No

*Emails may contain protected health information (PHI) that is confidential and legally protected. We always send PHI via secure email

Birth Date:_____ Age:_____ Sex:_____ Male _____Female

Soc Sec:_____

IN CASE OF EMERGENCY NAME/NUMBER:_____

Did you come here for an emergency today? Any dental concerns? _____

_____

How did you hear about us? ___ Friend ___ Family ___ Social Media ___ Web Search ___ Other

Who can we thank for referring you to us? _____

TRANSFERRING FROM ANOTHER DENTAL OFFICE

Name of previous dentist office (within the last 1-2 years):

_____

Name Address (City/State) Phone#

_____

Approximate Date Last Seen? Were X-Rays Taken?