CENTERPOINT
ADVANCED RESTORATIVE
& ESTHETIC DENTISTRY
(972) 480-0800

NEW PATIENT REGISTRATION

PATIENT INFORMATION:

First Name: _____ Last Name: _____ MI: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Ext: _____ Home Phone: _____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birthdate: _____ Age: _____ Soc Sec: _____ DL#: _____

Email: _____ ☐ I would like to receive correspondences via email

Referred By: ☐ Internet ☐ Insurance ☐ Ad ☐ Friend: _____ ☐ Other: _____

Emergency Contact: _____ Emergency Contact #: _____

---- RESPONSIBLE PARTY: (IF SOMEONE OTHER THAN THE PATIENT) ----

First Name: _____ Last Name: _____ MI: _____

Address: _____

Cell Phone: _____ Work Phone: _____ Ext: _____ Home Phone: _____

Birthdate: _____ Age: _____ Soc Sec: _____ DL#: _____

Email: _____ ☐ I would like to receive correspondences via email

---- PRIMARY INSURANCE INFORMATION: ----

Primary Subscriber's Name: _____ Insurance Company: _____

Subscriber's DOB: _____ Ins. Phone #: _____

Subscriber's Zip Code: _____ Member ID#: _____

Subscriber's Employer: _____ Group #: _____

Subscriber's SS#: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

---- SECONDARY INSURANCE INFORMATION: ----

Secondary Subscriber's Name: _____ Insurance Company: _____

Subscriber's DOB: _____ Ins. Phone #: _____

Subscriber's Zip Code: _____ Member ID#: _____

Subscriber's Employer: _____ Group #: _____

Subscriber's SS#: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

SIGNATURE: _____ DATE: _____