Cosmetic & Restorative Dental Care

Joseph J. Portale, D.M.D., M.A.G.D.

New Patient Registration Information

Date: _____

Section I — Patient Information

Name: _____ I Prefer to be called: _____

Address: _____

City, State, Zip: _____

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

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

The best time to contact me is: _____ ☐A.M. ☐P.M. on my ☐Home phone ☐Work phone ☐Cell phone

Is it permissable to contact you at work? ☐Yes ☐No Best Time: _____

Date of Birth: _____ Social Security #: _____

Spouse or Parent's Name: _____

Employer _____ Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency: _____ Phone _____

Driver's Lic.#: _____ State: _____ Exp. Date: _____

E-mail address: _____ Would you like to receive our e-newsletter? ☐Yes ☐No

Section II — Responsible Party

Relationship to Patient: ☐Self ☐Spouse ☐Parent ☐Other

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Social Security #: _____

Section III — Insurance Information

Name of Insured _____ DOB _____ Relationship to Patient _____

SSN# _____ Name of Employer: _____ Work Phone: _____

Address of Employer _____ City/State/Zip _____

Insurance Company _____ Grp# _____ ID# _____

Ins Co. Address: _____ Ins Co. Phone: _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐YES ☐NO IF YES, COMPLETE THE FOLLOWING

Name of Insured _____ DOB _____ Relationship to Patient _____

SSN# _____ Name of Employer: _____ Work Phone: _____

Address of Employer _____ City/State/Zip _____

Insurance Company _____ Grp# _____ ID# _____

Ins Co. Address: _____ Ins Co. Phone: _____

Please briefly describe the reason for your visit today: _____

How did you choose our office? ☐Yellow Pages ☐Referred by friend ☐Live in neighborhood ☐Referred by Dr.: _____ ☐Newspaper, Radio, Mailing ☐Other: _____

Submit