Jennifer S. Emerson, DDS

Initial Patient Registration Form

Date _____

Name of Patient _____
First Middle Last Nickname

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child Birth Date _____ Social Security # _____

Person Responsible for Account _____ Relationship to Patient _____

Home Address _____
Street City State Zip

E - mail Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Please circle the number where you prefer to be reached.

Name of Your Employer _____ Occupation _____

Please complete this section if you would like us to submit to your dental insurance:

Name of Insured Person _____ Relationship to Patient _____

Insured's Birth Date _____ Social Security # _____ ID# _____

Name of Insurance Company _____ Coverage Started _____

Address to send claims _____
Street City State Zip

Insurance Company Phone _____ Group/Policy # _____

Do you have dental insurance coverage through any other plan? ☐ YES ☐ NO
(if yes, please provide the same information on separate paper).

Person to contact in case of emergency: _____
Name Phone

Names of immediate family members: _____

Who may we thank for referring you to our office? _____

Jennifer S. Emerson, DDS

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