Dental Horizons
Guiding Generations to Healthy Smiles

Adult Patient Registration

Today's Date_____

Name: _____ Marital Status_____
Last *First* *MI*

Home Phone # _____ Cell Phone # _____ Work Phone #_____

Address: _____ Date of Birth: _____
Apt # *City* *State* *Zip*

SS#_____ Email: _____ Age_____ Male □ Female □

Employer_____
Name *Address*

Please provide a copy, screen shot, or digital photo of your Dental Insurance information.
Or fill out the information below:

Dental Insurance _____
Company *Group #* *Address*

Name of Insurance Policy Holder: _____
Last *First* *MI*

Insurance Policy holder's information:

Date of Birth _____ Age_____ Social Security #: _____

Employer_____
Name *Address*

Dental Insurance (Secondary) _____
Company *Group #* *Address*

How were you referred to this office? □ Friend or Family (Name) _____
□Community Event □ Yellow Pages □ Facebook □ Walk in □ Mailer
□ Internet site _____ □ Referred by Dr. _____ □Other _____

How will today's services be taken care of? □ Cash □ Check □ Credit Card (MC/Visa)

I certify that the above information is complete and accurate and the information on the Medical History, Dental History, and Sleep Screen Questionnaires.

_____
Signature of Patient, Parent or Guardian *Date*

All forms can be submitted electronically via fax, e-mail or digital photo