Mt Baldy Dental Center

Patient Registration

Patient First Name:_____ Last Name:_____ Middle Initial:_____
Preferred Name:_____
Name of Responsible Party:_____

Address:_____ Address 2:_____
City, State, Zip:_____
Seasonal/Other Address:_____
Cell Phone:_____ OK to send appointment reminders via text:____ Yes _____ No
Work Phone:_____ Ext:_____ Home Phone:_____
Email:_____ OK to send communication via email:_____ Yes _____ No
Birth Date:_____ Age:_____ Sex: _____ Male _____Female
Soc Sec:_____ Drivers Lic:_____
IN CASE OF EMERGENCY NAME/NUMBER:_____

TRANSFERRING FROM ANOTHER DENTAL OFFICE
Name of previous dentist office (within the last 2-3 years):

_____
Name Address(City/State) Phone #

_____
Approximate Date Last seen? Were X Rays Taken?

PRIMARY INSURANCE INFORMATION (only needed if no card is present)
Is this plan through an employer or a self plan:_____
Who is your employer?_____
Name of Insured:_____ Insured Birth Date:_____
Relationship to Insured:_____ Self _____ Spouse _____ Child _____ Other
Insurance Provider:_____
Member ID:_____ Group #:_____
Insurance Address:_____
Insurance Phone Number:_____

SECONDARY INSURANCE INFORMATION (only needed if no card is present)
Is this plan through an employer or a self plan:_____
Who is your employer?_____
Name of Insured:_____ Insured Birth Date:_____
Relationship to Insured:_____ Self _____ Spouse _____ Child _____ Other
Insurance Provider:_____
Member ID:_____ Group #:_____
Insurance Address:_____
Insurance Phone Number:_____