Mt Baldy Dental Center
Patient Registration

PATIENT INFORMATION

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

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

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:____