ADULT NEW PATIENT REGISTRATION

919-859-1000 | email to: team@dentistrybydesignofcary.com

DENTISTRY by DESIGN of Cary
Evidence-Based Medicine

1. **ADULT PATIENT INFORMATION**
   - Today's date: _____
   - Patient's name: _____
   - Preferred name: _____
   - Date of birth: _____
   - Social security #: _____
   - Address: _____
   - City: _____ State: ____ Zip: _____
   - Cell #: _____ Home #: _____ Work #: _____
   - E-mail: _____
   - Best way to contact you: _____
   - Marital status. Please check one:
     ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
   - Name of employer: _____
   - Your occupation: _____
   - How did you find our practice? _____
   - Name of emergency contact: _____
     Relationship to patient: _____ Phone #: _____

2. DENTAL INSURANCE

Choose one of the following options which apply to you

☐ I have dental insurance. **COMPLETE THIS SECTION**

OR

☐ I do not have dental insurance. **SKIP THIS SECTION AND MOVE TO SECTION 4**

- Name of insurance company: _____
- Telephone #: _____
- Subscriber/Member ID #: _____
- Group #: _____
- Claims mailing address: _____
- City: _____ State: _____ Zip: _____

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3. SUBSCRIBER (The person who owns the dental insurance policy)

Choose one of the following options which apply to you.

☐ I am not the subscriber for my dental insurance. **COMPLETE THIS SECTION**

OR

☐ I am the subscriber for my dental insurance. **SKIP THIS SECTION AND MOVE TO SECTION 4**

- Name of the subscriber: _____ Date of birth: _____
- Social security #: _____
- Relationship to the patient: _____
- Address: _____
- City: _____ State: _____ Zip: _____
- Best phone # to be contacted at: _____
- Name of employer: _____
- Occupation: _____
- Work phone #: _____

4. NAME ON ACCOUNT AND RELATIONSHIP

Choose one of the following options which apply to you.

☐ I want my statements sent to me, I will be the name on the account.

OR

☐ I have other family members coming here and want to be on their account.
I want my statements sent to the name on this account.

- Name on the Account: _____
- Relationship to the patient: _____

I understand that I am responsible to inform this office of any changes to the information I have provided on this form prior to any appointment in order to prevent any delay in processing claims and statements.

Printed Name: _____

If other than patient, indicate relationship to patient: _____

Date: _____ Signature:_____

Date: _____ Witness:_____