Heritage
Family Dental, P.C.

Adult Patient Registration

Patient Information

Name: _____ ____ _____ I prefer to be called: _____
First MI Last

Birthdate: _____ SS# _____ □Male □Female
month/day/year

□Single □Married □Divorced □Widowed □Separated

Mailing Address:	Physical Address (if different):
City State Zip	City State Zip

Employer: _____ How Long? _____

Telephone Contact Numbers

Home:	Work:
Mobile:	Other:

May we call you at work? □Yes □No
May we text you appointment reminders? □Yes □No

Best time to reach you: □Mornings □Afternoons
At which number: □Home □Work □Mobile □Other
Please indicate the contact numbers that we have permission to leave a detailed message:
□NONE □Home □Work □Mobile □Other

Email:

Can we email you appointment reminders? □Yes □No

Do you have pre-school or school-aged children living in your household? □Yes □No
Who may we THANK for referring you? _____

Dental Insurance Information

Primary DENTAL Insurance	Secondary DENTAL Insurance
Insurance Company	Insurance Company
Insurance Phone Number	Insurance Phone Number
Policy Holder's Name	Policy Holder's Name
Group Number	Group Number
Policy Holder's Address (if different from above) _____ _____ _____ _____ City State Zip	Policy Holder's Address (if different from above) _____ _____ _____ _____ City State Zip
Policy Holder's Phone Number	Policy Holder's Phone Number
Policy Holder's Relationship to Patient □Self □Spouse □Parent □Other:	Policy Holder's Relationship to Patient □Self □Spouse □Parent □Other:
Policy Holder's Birth date	Policy Holder's Birth date
Policy Holder's SS#	Policy Holder's SS#
Insured's Employer	Insured's Employer