

New Patient Registration Form

Please complete the following information



Patient Name:

If child, name of presenting parent or guardian:

Date of Birth: _____ Age: _____ Home Phone Number: _____
Home Address: _____ Work Phone Number: _____
Cell Phone Number: _____
City: _____ State: _____ ZIP: _____ Email Address: _____

Who is the person responsible for this account? (Check box)

PATIENT | PARENT | SPOUSE | STEP PARENT | GUARDIAN

Name of Person Responsible: _____ Phone: _____
Address: _____
City: _____ State: _____ ZIP: _____

Whom may we contact in an emergency?

Name: _____ Whom may we thank for this referral? _____
Relationship: _____ What are your hobbies and interests? _____
Phone: _____ Are any of your other family members treated at our practice? If so, who? _____

Patient's Primary Insurance: _____	Patient's Secondary Insurance: _____
Subscriber: First, MI, Last _____	Subscriber: First, MI, Last _____
ID#: _____ Birth Date: _____	ID#: _____ Birth Date: _____
Social Security Number: _____	Social Security Number: _____
Employer Name: _____	Employer Name: _____
Group #: _____	Group #: _____
Insurance Carrier Name: _____	Insurance Carrier Name: _____
Insurance Carrier Address: _____	Insurance Carrier Address: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____

Fallston Dental Care, Frederick W. Parker, D.D.S., P.A. | 2106 Fallston Road, Fallston, MD 21047 | Phone 410.893.0513 | Fax 443.299.6370

By completing this form, you certify that all information provided to Fallston Dental Care is true, correct, and complete and agree to promptly inform Fallston Dental Care of any changes in any information (including regarding any dependent). Fallston Dental Care is authorized to use and disclose to any insurance, billing, management, or processing company, agency or organization any health care information/medical records relating to the patient or any dependent to obtain payment for services, determine insurance benefits or otherwise as required by law. Fallston Dental Care is authorized to contact the patient at any telephone number provided above (unless otherwise revoked in writing) to discuss this form and any billing, treatment, or other matter related to any dental treatment (including for any dependent). Please note our Personal Health Information Privacy Policy posted in the office.