EVERGREEN
Dental Care

PATIENT REGISTRATION FORM

Date _____

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Who may we thank for referring you? _____

If you were not referred, how did you hear about us? _____

PATIENT INFORMATION

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ Cell Phone _____

Email _____ State _____ Zip _____

Best method of contact (Circle one) : e-mail cell phone home phone text message

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If student, name of school _____ City _____ State _____ ☐ Full-time ☐ Part-time

Patient or parent/guardian's employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Spouse/Parent/Guardian's name _____ Employer _____ Work phone _____

Emergency contact _____ Phone _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship _____

Address _____ Home phone _____ Cell Phone _____

Email _____ Birthdate _____ State _____ Zip _____

Are you currently a patient in our office? ☐ Yes ☐ No Driver's license # _____

Employer _____ Work phone _____ SSN _____

We offer the following methods of payment. Please check the option you prefer.

☐ Cash ☐ Personal Check ☐ VISA ☐ MasterCard ☐ CareCredit

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____

Birthdate _____ SSN _____ Date employed _____

Name of employer _____ Work phone _____

Employer address _____ City _____ State _____ Zip _____

Insurance _____ Group# _____ _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No If **YES**, complete the following:

Insurance _____ Group# _____ Policy/ID# _____