

New Patient Registration Form

RUCHI GROVER, D.D.S. GENTLE DENTISTRY

Today's date _____

PERSONAL INFORMATION

First name _____ M.I. _____ Last name _____

Address _____

Town _____ State _____ Zip _____

Mailing address, if different _____

Home Ph. _____ Work Ph. _____ Cell _____

Date of birth ____/____/____ Email _____

Marital status Single Married Divorced Separated Widowed

In case of emergency contact _____ Ph. _____ Alt. Ph. _____

How did you find out about Gentle Dentistry? (Please check all that apply.)

I was referred by _____ I saw your website Other internet listing Yellow Pages I saw your sign Other

Would you like to be on our "quick call list" for appointments that are available on short notice? Yes No

PAYMENT INFORMATION

Payment is due at the time of service. We accept cash, checks, Mastercard, Visa, and Discover credit cards.

Who is the responsible party for your dental bills? Self Other If other, Name _____

Address of responsible party (if not you) _____

Email _____ Ph. _____ Alt. Ph. _____

Do you have dental insurance? Yes No If yes, name of Insurance Plan/Carrier _____

Name of employer who provides insurance _____

Ins. Group ID# _____ Dental Ins. ID# _____

Your Soc. Sec. # (if required by insurance plan) _____ Relationship to the insured Self Spouse Child Other

Dental insurance subscribers name _____

Dental insurance subscribers birthdate _____

DENTAL INFORMATION

Are you having a dental problem at this time? If so, please explain _____

Please let us know if you have any concerns or anxieties related to your dental care _____

When was your last dental exam _____ last dental cleaning _____ or last set of dental x-rays taken _____?

In order to avoid unnecessary x-rays it is essential that you arrange for x-rays taken in the last five years to be forwarded to this office.

Do you wish to receive a copy of our notice of Privacy Practices? Yes No

Signature _____ Date _____