



(* denotes required)

5500 Ming Ave Ste 165
Bakersfield, CA, 93309-9118
Phone - (661) 835-8785, Fax - (661) 835-8786

Patient Registration

Personal Information

First Name*

.....

Middle Initial

.....

Last Name*

.....

Date of Birth*

.....

Gender*

☐ Female

☐ Male

Social Security Number

(Used for insurance purposes)

.....

How did you hear about our office?*

☐ Insurance Company

☐ Facebook

☐ Instagram

☐ Current Patient

☐ Drive By

☐ Google Search

Address

Street Address*

.....

Street Address (cont.)

.....

City*

.....

State*

.....

Zip Code*

Contact Preferences

Email Address

Mobile Phone Number*

Home Phone Number

Emergency Contact

First Name

Last Name

Phone Number

Relationship to Patient

- ☐ Daughter
- ☐ Father
- ☐ Friend
- ☐ Life Partner
- ☐ Mother
- ☐ Other Relationship
- ☐ Significant Other
- ☐ Sister
- ☐ Son
- ☐ Spouse

Additional People on this Account

Person Responsible for Account (if different from patient)

(First and last name of the responsible party)

Phone Number of Responsible Party (if different from patient)

Relationship to Patient

- ☐ Father
- ☐ Mother
- ☐ Spouse
- ☐ Other

Dental Insurance

Policy Holder's First Name

.....

Policy Holder's Last Name

.....

Policy Holder's Date of Birth

.....

Name of Insurance Company

.....

Policy Number/Member Number/Subscriber ID

.....

Group Number

.....

Name of Employer

.....

Insurance Company Phone Number

.....

Do you have a secondary dental insurance policy?

(If yes, please provide secondary dental insurance information to an office team member.)

☐ YES

☐ NO

Patient Signature