Dianne Applegate, DDS, LLC
Family Dentistry

NEW PATIENT REGISTRATION

Welcome! Thank you for choosing us to help you with your dental needs. We are committed to providing the highest quality dental care in the most gentle, informative and cost effective manner possible.
The more we know about you, the better we can help.

PATIENT INFORMATION

Patient's Name____
First Middle Initial Last

Preferred Name____

Which of the following describes your current status?
☐ Adult ☐ Minor DOB _________________

SSN ____________________

Address ____

City ________________________

State _____ Zip ______________

Best Phone to reach you (_____)_____________________

Secondary Phone (_____)________________________

Message Phone (_____) _______________________

Email ______________________________________(not public)

Responsible Party ____________________________________

Responsible Party SSN _______________________________

Preferred Method of Payment:
☐ Cash ☐ Check ☐ Credit Card ☐ CareCredit

Parent/guardian's name if patient is a minor:

____

Other family members who are patients here:

____

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Interested in more information for:
☐ Teeth Whitening ☐ Invisalign

DENTAL INSURANCE
Primary Coverage

Subscriber ____________________ DOB __________

Group _______________ID/ SSN__________________

Employer ___________________________________

Insurance Co ______________________________

Address ___________________________________

City ________________ST _____ Zip_________

Customer Service (_____)____________________

DENTAL INSURANCE
Secondary Coverage

Subscriber ____________________ DOB ________

Group ______________ID/ SSN_________________

Employer ___________________________________

Insurance Co ______________________________

Address ___________________________________

City ________________ST _____ Zip_________

Customer Service (_____)____________________

In case of an emergency, please notify (Name/Phone)

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Whom may we thank for referring you to our office?

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