



**NOELCK & MA FAMILY
DENTISTRY**

PATIENT REGISTRATION FORM

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____ Date Of Birth: _____

SSN: (If required for insurance ID purposes): _____ Gender: Male Female Prefer not to say Other: _____

Email Address: _____ Marital Status: Single Married Divorced Widowed Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Contact Method: Phone Text Email

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Full Name: _____ DOB: _____ Relationship: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Contact Method: Phone Text Email

EMERGENCY CONTACT INFORMATION

Full Name: _____ DOB: _____ Relationship: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Preferred Contact Method: Phone Text Email

CONSENT FOR COMMUNICATION

I authorize this dental office to contact me regarding appointments, treatment details, billing statements, and other related dental care information via: Phone Text Message Email (I understand that standard messaging rates may apply for text communications.)

Patient/Responsible Party Name: _____ Signature: _____ Date: _____

AUTHORIZATION TO DISCUSS INFORMATION

I authorize the following individuals to discuss my appointments, treatment plans, and account information with the dental office:

Full Name: _____ DOB: _____ Relationship: _____ Phone: _____ Email: _____

Full Name: _____ DOB: _____ Relationship: _____ Phone: _____ Email: _____

No one other than myself may receive information

Patient/Responsible Party Name: _____ Signature: _____ Date: _____

PRIMARY DENTAL INSURANCE INFORMATION

Sub Name: _____ Sub DOB: _____ Relationship to Patient: Self Spouse Child Other: _____

Employer Name: _____ Employer Address: _____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Member/Subscriber ID #: _____ Group Number: _____

SECONDARY DENTAL INSURANCE INFORMATION (IF APPLICABLE)

Sub Name: _____ Sub DOB: _____ Relationship to Patient: Self Spouse Child Other: _____

Employer Name: _____ Employer Address: _____

Insurance Company Name: _____ Insurance Phone Number: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Member/Subscriber ID #: _____ Group Number: _____

ACKNOWLEDGEMENT

I certify that the above information is accurate to the best of my knowledge. I understand that providing incorrect information may affect my treatment or insurance processing.

Patient/Responsible Party Signature: _____ Date: _____