



New Patient Registration

Office: ☐ **Grand Prairie**
(972) 262-5593☐ **Arlington**
(682) 284-1120☐ **Commerce**
(903) 246-4424☐ **Paris**
(903) 609-0567

Please complete this form before your first visit. Print clearly or fill it in on your computer and print it.

Patient information

First name

Middle name

Last name

Preferred name

Date of birth (MM/DD/YYYY)

Sex: ☐ Female ☐ Male ☐ Other

Street address

Apt./Unit

City

State

ZIP code

Cell phone

Home phone

Email

Preferred contact: ☐ Phone call ☐ Text message ☐ Email**Preferred language:** ☐ English ☐ Spanish**How did you hear about us?** ☐ Google ☐ Facebook ☐ Friend or family ☐ Insurance plan☐ Drove by ☐ Other:

Responsible party or parent/guardian

Complete if the patient is under 18 or someone else is responsible for the account.

Full name

Relationship to patient

Phone

Date of birth

Address, if different from patient

Emergency contact

Full name

Relationship

Phone



Dental insurance

Please bring your insurance card to your visit. Leave blank if you do not have dental insurance.

Primary insurance

Insurance company

Member ID

Group number

Subscriber name

Subscriber date of birth

Relationship to patient

Subscriber's employer

Secondary insurance (if any)

Insurance company

Member ID

Group number

Subscriber name

Subscriber date of birth

Relationship to patient

Subscriber's employer

Medicaid or CHIP ID (optional)

Plan name (optional)

Dental care

Previous dentist

Phone

Date of last dental visit

Reason for today's visit

Signature

I certify that the information on this form is accurate and complete to the best of my knowledge. I will tell the office if any of it changes.

Signature of patient or parent/guardian

Date

Printed name

Relationship to patient