Modern
FAMILY DENTAL CARE

We create a beautiful, confident, and healthy smile for everyone.

New Patient Registration

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

How did you learn of Modern Family Dental Care?
Direct Mailing   Friend/Relative   Internet Search   Insurance Plan   Newspaper Ad   Exterior Sign   Facebook   Twitter
Other____________________ If you were referred, whom may we thank for referring you?________________________

Patient Information

Name ____________________ Nickname ____________ Sex M F
SSN ____________________ Birth date ____________ Cell Phone ____________
Address ______________________________ Home Phone ____________
City ____________ State ____ Zip ____________ Work Phone ____________
Email ____________________ Facebook ____________ Twitter ____________
Check appropriate box: Minor Single Married Divorce Widowed Separated
If student, name of school ____________ FT / PT City ____________ State ____ Zip
Patient or parent/guardian's employer ____________________ Work Phone ____________
Employer Address ____________________ City ____________ State ____ Zip ____
Emergency Contact ______________________________ Phone ____________

Responsible Party

Name of person responsible for account ____________________ Relationship to Patient ____________
Address ______________________________ Cell Phone ____________
City ____________ State ____ Zip ____________ Home Phone ____________
Email ____________________ DOB ____________ Work Phone ____________
Are you currently a patient of this office? Yes No ____________ Drivers License # / State ____________
Employer ______________________________ SSN ____________

Insurance Information

Name of Insured ______________________________ Relationship to Patient ____________
DOB ____________ SSN ____________ Date Employed ____________
Name of Employer ____________ Address ____________ Work Phone ____________
City ____________ State ____ Zip ____________ Home Phone ____________
Insurance ____________ Group # ____________ Policy/ID # ____________
Insurance Address ____________ City ____________ State ____ Zip ____________

Consent

I will answer all health questions on the Medical History From to the best of my knowledge________ (Initials)

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature ______________________ Date____________ Relationship to Patient______________