Cliffside Park
DENTAL GROUP

New Patient Registration Form

(All information will be kept confidential)

First Name: _____Last Name: _____ M.I. _____

Patient Information

Address:_____

City:_____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Age: _____ Social Security Number: _____

Sex: M__ F__ Email Address:_____

Emergency Contact Name: _____ Phone Number: _____

Responsible Party (Complete if patient is a minor or someone other than the patient is responsible for payment)

First Name: _____Last Name: _____ M.I. _____

Address:_____

City:_____State:_____Zip:_____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: _____

Primary Dental Insurance Information

Name of Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Birth Date: _____ Relationship to Patient: Self__ Spouse__ Parent__ Other__

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

Secondary Dental Insurance Information

Name of Policy Holder: _____ Policy Holder's SSN: _____

Policy Holder's Birth Date: _____ Relationship to Patient: Self__ Spouse__ Parent__ Other__

Employer: _____ Dental Insurance Company: _____

Dental Insurance ID #: _____ Dental Insurance Group #: _____

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Other

How did you hear about us? _____

If referred, whom may we thank? _____

Please sign and date this form below. Your signature below indicates that the information on this is complete and accurate to the best of your knowledge.

Signature:_____ Date:_____