High Tide Dentistry

Patient Registration

First Name: ___________________ Last Name: _______________________

Date of Birth: ___________ SSN: ______________________

Mailing Address:

____

City_______________________________ State __________ Zip___________

Home Phone: __________________ Cell Phone: ______________________

Responsible Party (ONLY COMPLETE IF SOMEONE OTHER THAN PATIENT)

First Name: _________________ Last Name_________________________

Date of Birth: ___________ SSN: ________________________

Mailing Address:____

Home Phone: ___________________ Cell Phone: ____________________

Insurance Information:

Name of Insured: ___________________________________

Relationship to Insured: ____________________

Insured SSN: __________________ Insured Date of Birth: _____________

Employer:

____

Please let our Patient Coordinator know if you have secondary coverage

EMAIL ADDRESS: ____