Dr. Lori Trembath, DDS, PC
Family Dentistry

NEW PATIENT REGISTRATION FORM

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Address: _____ Address (Second Line): _____

City: _____ State/Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: ____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____

Email: _____ I would like to receive correspondences via email: ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Contract ☐ Retired ☐ Other

Student Status: ☐ Full Time ☐ Part Time ☐ Not Applicable

Referred By: _____ Previous Dentist: _____

Emergency Contact Name: _____ Emergency Contact Phone Number: (____) _____

Responsible Party (If someone other than patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address (Second Line): _____

City: _____ State/Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____ Ext: ____

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _____ Age: _____ SSN: _____ Drivers License: _____

Email: _____ I would like to receive correspondences via email: ☐ Yes ☐ No

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Co.: _____

Address: _____ Address: _____

Address (Second Line): _____ Address (Second Line): _____

City, State/ Zip: _____ City, State/ Zip: _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Insurance Co.: _____

Address: _____ Address: _____

Address (Second Line): _____ Address (Second Line): _____

City, State/ Zip: _____ City, State/ Zip: _____

Collections

I agree to pay any dental bill I incur when it is due. If my account is sent to collections, I agree to pay all costs to collect my bill including collection agency costs, attorney's fees and court costs.

Sign:_____Print Name:_____ Date:_____

I agree that my credit card maybe charged to pay my account if it is more than 60 days overdue.

O MC O Visa O Discover Credit card # _____Expiration Date:_____

Sign:_____Print Name:_____ Date:_____