Dental Wellness
of Westlake Village

NEW PATIENT REGISTRATION FORM

Name _____ Pref Name _____

Birth Date ____ / ____ / ____ Social Security Number _____

Address _____ City _____ State _____ Zip _____

Phone (Home) _____ (Cell) _____ (Work) _____

Email _____

◯ Male ◯ Female **Marital Status** Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed ◯

Employer _____ Occupation _____

Preferred Pharmacy _____

How do you prefer to be contacted? Phone ☐ Email ☐ Text ☐

How did you hear about our office? Friend/Family ☐ Internet ☐ Mailer ☐ Walked by ☐ Insurance ☐

Whom may we thank for your referral? _____

Emergency Contact Name _____

Relationship _____ Phone _____

INSURANCE INFORMATION

Subscriber's Name _____ Relationship to Patient _____

Subscriber's Birth Date ____ / ____ / ____ Subscriber's Social Security / Insurance ID _____

Subscriber's Employer _____

Insurance Company Name _____

Group No. _____ Policy No. _____

Do you have additional / secondary insurance? Y ◯ N ◯

I authorized and request my insurance company to pay directly to the dentist or dentist's group insurance benefit otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services or not all services are covered. I agree to be responsible for payment of all services rendered on my behalf or my dependents. In addition, co-payments are due at the time that treatment is rendered.

Signature of Patient or Parent/Guardian _____ Date ____ / ____ / ____

SAVE PRINT

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