IMPERIAL FAMILY DENTAL CENTER

How did you hear about us? Radio Paper Website Direct Mail Facebook Referral Other

*****Who may we thank for referring you?_____**

Patient Registration

Last Name _____ First Name _____ Middle Initial _____

Physical Address _____Mailing Address (if different than physical) _____

City _____State _____Zip _____

Home Phone _____Mobile Phone _____(Receive Text Messages) **YES NO**

Employer _____ Work Phone _____

Email Address _____

Sex: (please circle) M / F Date of Birth_____

Social Security # _____Marital Status _____

Emergency Contact: _____ Phone_____

If patient is under the age 19

Guardian/Responsible Party Name_____Relationship to patient _____

Date of Birth_____ Social Security #_____

Primary Dental Insurance

Policy Holder Name: _____ Relationship to Patient _____

Policy Holder's Social Security Number _____ Policy Holder's DOB _____

Name of Insured's Employer _____ Phone Number of Employer _____

Insurance Company _____ Policy Number _____

Secondary Dental Insurance

Policy Holder Name _____ Relationship to Patient _____

Policy Holder's Social Security Number _____ Policy Holder's DOB _____

Name of Insured's Employer _____ Phone Number of Employer _____

Insurance Company _____ Policy Number _____