Destin Harbor Dental

Patient Registration

Patient Information

Last Name: ________________________ First Name: ______________________________ MI: ________
Address: ______________________________ City: ____________________ State: ________ Zip: __________
Sex: M / F   Check Appropriate box : ☐Minor ☐Married ☐Single ☐Divorced ☐Widowed
Date of Birth: __________________ Soc Sec: ________________ Drivers Lic: ________________________
Home Phone: _____________ Cellular: ________________ Work Phone ____________________ Ext: ________
E-Mail Address: ______________________________________

Responsible Party (if someone other than the patient)

Last Name: ________________________ First Name: ______________________________ MI: ________
Address: ______________________________ City: ____________________ State: ________ Zip: __________
Sex: M / F   Check Appropriate box : ☐Minor ☐Married ☐Single ☐Divorced ☐Widowed
Date of Birth: __________________ Soc Sec: ________________ Drivers Lic: ________________________
Home Phone: _____________ Cellular: ________________ Work Phone ____________________ Ext: ________
E-Mail Address: ______________________________________

Preferred Pharmacy: ____ Phone: ________________
☐ I would like to **receive appointment reminders and confirmations Via Text:** Phone: ________________

Referred By: ▫Business Referral: _______________ ▫Existing Patient: ______________ ▫Discover Northwest Florida Mailer ▫Google ▫Online other than Google ▫Facebook/Social Media ▫Phone Book ▫Psalm 91.1 ▫Indian Bayou Gulf Course ▫Our Business Website ▫Eglin AFB Guide ▫AMC Movie Theater ▫Other: _______________

In case of Emergency, Who should be notified? ____
Relationship to Patient: ___________________________ **Phone:** ________________________

Pref. Hygienist: ☐ **Susie** ☐ **Sylvia** (Thursday Afternoons Only)   ☐ **No Preference**

For Your Convenience, we offer the following methods of payment:

☐Cash   ☐Personal Check   ☐Visa/MasterCard/Discover   ☐Care Credit (Please furnish your Care Credit Card)

PRIMARY Dental Insurance Information (Must fill out completely, please furnish driver's License and Insurance Card)

Name of Insured: ______________________________ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Soc. Sec: ___________________________ Insured Date of Birth: ___________________________
Employer: ____________________________ Insurance Company: ________________________________
Claims Address: ________________________ City: _________________________ State: _______ Zip: ________
Grp #: _________________ ID #: ___________________ Ins. Phone: _____________________________

SECONDARY Dental Insurance Information (Must fill out completely, please furnish Insurance Card)

Name of Insured: ______________________________ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other
Insured Soc. Sec: ___________________________ Insured Date of Birth: ___________________________
Employer: ____________________________ Insurance Company: ________________________________
Claims Address: ________________________ City: _________________________ State: _______ Zip: ________
Grp #: _________________ ID #: ___________________ Ins. Phone: _____________________________

Signature of **patient** or **Parent/Legal Guardian** ______________________________ **Today's Date:** ____________