Tate Stimpson, D.M.D

Family & Cosmetic Dentistry

Patient Registration

Date: ____________________ Whom can we thank for this referral? ______________________________

Patient's Name ____ ________________

Last First Middle Preferred

Address ____

Street City State Zip Code

Home Phone (_____)____________________ Cell Phone (_____)____________________

Work Phone (_____)_______________ Primary Email Address ______________________________

Employer ____________________________________ Occupation ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Birthdate _________________________ Social Security No. ______________________

If Minor, List Parents' Names Father _________________________ Mother ____________________________

> **IF YOU HAVE DENTAL INSURANCE, WE WILL GLADLY SUBMIT YOUR CLAIM ON YOUR BEHALF. HOWEVER, WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE, AS THE INSURANCE POLICY IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE CARRIER.**
> **YOU WILL BE RESPONSIBLE FOR ANY FEES NOT COVERED BY YOUR INSURANCE COMPANY.**

Dental Insurance Information (Please provide a copy of your Dental Insurance Card.)

Do you have Dental Insurance: ☐ Yes ☐ No Name of Insurance Company ____________________________

Dental Insurance Company Address ____

Street City/State/Zip

Name of Policy Holder ____

Last First Middle

Social Security No. __________________________ Birthdate ____________________________________

Employer __________________________________ Group No. ____________________________________

Employer Phone (_____)________________ Relationship to Patient ____________________________

If You Have Secondary Insurance

Name of Secondary Policy Holder ____

Address of Insurance Company ____

Street City/State/Zip

Date of Birth __________________________ Social Security Number ______________________________

Name of Plan ___________________________ Group No. ____

Emergency Information

Name ____ Relationship _________________________

Complete Address ____

Street City/State/Zip

Home Phone: (_____)___________________ Work Phone (_____)_____________________

Getting To Know You

Is another member of your family a patient in our practice? Name ____________________________________

When was your last dental visit? __________ When was the last time you had complete dental x-rays? __________

Former Dentist: Name, Address, Phone ____

Why did you select our office? ____

We are all very pleased to meet you, and look forward to meeting your friends and family.

For All Patients ____

Signature (Parent if minor) Date