

Patient Registration Form

30 Bridge St (Suite 303)
New Milford, Ct 06776
860-354-9600

168 New Milford Tpk
New Preston, Ct 06777
860-868-0265

Patient Information:

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

Birth Date: _____ Social Security Number: _____

Sex M: ____ F: ____ Marital Status: Married: ____ Single: ____ Divorced: ____ Widowed: ____

Address: _____

City: _____ State: ____ Zip Code: _____

Cell Phone: _____ Email: _____

Home Phone: _____ Work Phone: _____

Last Dental Visit: _____ Previous Dentist: _____

Reason for Visit Today: _____

Referred by: _____

Responsible Party Information: (if other than patient)

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

Birth Date: _____ Social Security Number: _____

Relationship to Patient: _____

Address (if different from patient): _____

City: _____ State: ____ Zip Code: _____

Best Contact Phone Number: _____ Email: _____

Insurance Information:

Name of Employer: _____ Group number: _____

Name of Subscriber: _____

Subscriber SS# or Insurance ID#: _____ Subscriber Birth Date: _____

Insurance Company: _____

Secondary Insurance Information: (if applicable)

Name of Employer: _____ Group number: _____

Name of Subscriber: _____

Subscriber SS# or Insurance ID#: _____ Subscriber Birth Date: _____

Insurance Company: _____