UT Dentists
A Part of UTHealth

PATIENT REGISTRATION FORM

*Please complete **ALL** fields*

Today's date:	Appointment date:

PATIENT INFORMATION

Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Are you a NEW patient? ❑ Yes ❑ No	Primary Care Doctor:	Primary Doctor number:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address:	Parent/Legal Guardian Name:	Preferred Phone: ( )

Email:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer Phone: ( )

Do you have X-rays from another dentist? ❑ Yes ❑ No Date of last X-rays: / /

Referred by (please check one box): ❑ Insurance Plan ❑ UT Dentists Website

❑ Family ❑ Friend ❑ UTHealth or MD Anderson Employee ❑ UT Dentists Social Media ❑ Other

❑ **Referring Doctor Name**: **Referring Doctor Phone**:

INSURANCE INFORMATION

Please present your insurance card(s) and a valid ID at check-in

Subscriber Name:	Birth date: / /	Address (if different):	Preferred Phone: ( )

Primary policy holder? ❑ Yes ❑ No If no, relationship to subscriber: ❑ Spouse ❑ Child ❑ Other

Occupation:	Employer:	Employer address:	Insurance Phone: ( )

Name of Dental Insurance:

Subscriber/Member ID:	Group Number:	Effective Date: / /	Additional information:

Name of secondary insurance (if applicable):	Subscriber Name:	Subscriber ID:	Group Number:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:

Name of Medical Insurance (if applicable): Subscriber ID: Group Number:

Relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other: Insurance Phone: ( )

IN CASE OF EMERGENCY

Emergency Contact Name:	Relationship:	Cell Phone: ( )	Home or Work Phone: ( )

By signing this form, I attest that the above personal and insurance information provided is true to the best of my knowledge.

Patient/Guardian signature *Date*