Del Dental Group

8035 W. Manchester Ave., Suite B
Playa Del Rey, CA 90293

NEW PATIENT REGISTRATION		
PATIENT INFORMATION (CONFIDENTIAL)		
Name:		Date:
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Check appropriate box: Minor Single Married Divorced Widowed Separated		
If College Student: Fulltime Part time	Name of School:	
School City:	School State:	
Patient's or Parent/Guardian's Employer:		Work Phone:
Employer's Address:		
City:	State:	ZIP Code:
Spouse or Parent/Guardian's Name:		
Employer:		Work Phone:
Whom may we thank for referring you?		
Person to contact in case of emergency:		Phone:
RESPONSIBLE PARTY		
Name of person responsible for this account:		Relationship to patient:
Address:		Home phone:
Driver's License #:	Birth date:	SSN:
Employer:		Work phone:
Is this person current a patient in our office?		
INSURANCE INFORMATION		
Name of insured:		Relationship to patient:
Birth date:	SSN:	Date employed:
Employer:	Union or Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?
Do you have any additional insurance? Yes. No. If yes, complete the following:		
ADDITIONAL INSURANCE INFORMATION		
Name of insured:		Relationship to patient:

NEW PATIENT REGISTRATION		
Birth date:	SSN:	Date employed:
Employer:	Union for Local #:	Work phone:
Employer's Address:		
City:	State:	ZIP Code:
Insurance Company:		
Insurance Co. Address:		
City:	State:	ZIP Code:
Phone:	Group #:	Policy/ID #:
How much is your deductible?	How much have you used?	Max annual benefit?
SIGNATURES		
Signature of patient or parent/guardian if minor.		Date: