Patient Registration

PATIENT DETAILS

First Name: **Middle Name:** **Last Name:**

Date of Birth: **Gender:** **Male:** ☐ **Female:** ☐ **Marital Status:**

Home Address:

City: **State:** **Zip:**

CONTACT INFORMATION

Email: **Home Phone Number:**

Cell Phone Number: **Work Phone Number:**

Communication Preference: **Email** ☐ **Text** ☐ **Phone** ☐

RESPONSIBLE PARTY INFORMATION

Relationship to Patient:

First Name: **Middle Name:** **Last Name:**

Date of Birth:

Address:

City: **State:** **Zip:**

Patient registration information is necessary to process patient's request for dental services, dental insurance claims, and treatment history. Information can be used to contact patients for appointment reminders, claim verification, and payment options. Please inform the office if you are not able to provide this information prior to your initial appointment.

Stellar Family Dental
3190 N. Poinciana Blvd., Suite 100
Kissimmee, FL 34746
(407) 663-5000
3190@stellarfamilydental.com

PRIMARY INSURANCE INFORMATION

Policy Holder Name:

Relationship to Patient: **Date of Birth:**

First Name: **Middle Name:** **Last Name:**

Home Address :

City: **State:** **Zip:**

Employer Name **Insurance Company Name**

Member ID Number: **Group Number:**

SECONDARY INSURANCE INFORMATION

Policy Holder Name:

Relationship to Patient: **Date of Birth:**

First Name: **Middle Name:** **Last Name:**

Home Address :

City: **State:** **Zip:**

Employer Name: **Insurance Company Name:**

Member ID Number: **Group Number:**

Patient Signature: _____ **Date:**_____

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