Icon Dentistry PA
Patient Registration Information

Patient Name_____Preferred Name _____

Social Security #_____ Date of birth _____ Sex ☐ M ☐ F

Mobile_____ Home_____ Work_____

Address _____

City_____ State_____ Zip code _____

Driver's license #_____ Issued by state _____

Email address _____

Employer _____ Occupation _____

Marital status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

If you are a minor, parent or guardian name _____ Date of birth_____

Preferred language ☐ English ☐ Spanish ☐ Other_____
If other, can you bring an interpreter? ☐ Yes ☐ No

How did you hear about us? ☐ Patient referral – name of patient_____
☐ Web search ☐ Insurance carrier ☐ Postcard/mailer ☐ Advertisement ☐ Website ☐ Employee

Emergency Contact

Contact name _____ Relationship_____

Phone_____ Email address_____

Insurance Information

Please fill this section out if you are a new patient or if your insurance information has changed. Thank you.

Name of insured (if different than self)_____ Insured DOB_____

Insured employer_____

Insured address (if different than patient)_____

Insurance carrier_____ Carrier phone _____

Group number_____ Member ID/number_____