UTHealth
The University of Texas Health Science Center at Houston

School of Dentistry
Greenspoint

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 ❑ UTHealth Dentistry Greenspoint Website ❑ Family ❑ Friend ❑ UTHealth or MD Anderson Employee ❑ 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*					