Urgent Dental Care of New Hampshire
Patient Registration Form

How did you hear about us? _____
How Long Since Your Last Dental Visit_____
Are you experiencing any dental problems at this time_____

Patient First Name_____ Last Name_____
Date of Birth_____ S.S. Number_____
Email address (this will help us confirm your appointments, we will not share your email with anyone or send you spam mail)_____
Mobile Phone_____ Home Phone_____
Office Phone_____ Which Phone preferred?_____
Home address_____ City_____
State _____ Zip Code_____
Employer_____ Work Phone_____
Employer's Address_____
Emergency Contact Name_____ Relationship to patient_____
Emergency contact Phone(s)_____
What is your Marital Status? Single □ Married □ Widowed □
Spouse's Name_____ Spouse's Date of Birth_____
Spouse's Employer_____ Spouse's Work Phone_____

Dental Insurance company_____ Group #_____
Insurance company phone_____

For patients under 18 years of age
Parent or Guardian information: Mother □ Stepmother □ Guardian □
Name_____ Address_____
City_____ State_____ Zip Code_____
Mobile Phone_____ Home Phone_____ Work Phone_____
Employer_____ Occupation_____
Employer Address_____ S.S. #_____
Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

Parent or Guardian information: Father □ Stepfather □ Guardian □
Name_____ Address_____
City_____ State_____ Zip Code_____
Mobile Phone_____ Home Phone_____ Work Phone_____
Employer_____ Occupation_____
Employer Address_____ S.S. #_____
Marital Status: Single □ Married □ Separated □ Divorced □ Widowed □

I hereby authorize Urgent Dental Care of NH and its affiliates to provide me (or my child) any advisable, necessary dental procedures, medications, or anesthetics to be administered by the doctors or staff for diagnostic purposes or dental treatment. I understand that my care may be referred to dental specialists or affiliated practices when necessary. I understand and acknowledge that I am financially responsible for the services rendered, regardless of insurance coverage, which may only be estimated at time of treatment. Insurance estimates are not a guarantee of reimbursement.

Signature of Patient, Parent or Guardian_____ Date_____