*Please complete and bring to appointment*

Nevada Dental Benefits, Ltd.®
a PRIMECARE™ company

# PATIENT REGISTRATION

Nevada Dental Benefits, Ltd. (NDB) requests this information for the purposes of providing a complete and comprehensive evaluation of your dental needs. No persons outside of NDB will be provided this information unless properly authorised by you or required by law. Failure to provide the requested information will limit our ability to assess your needs and may result in NDB being unable to accept you as a patient.

## PATIENT DATA

| | | | |
|---|---|---|---|
| ☐Mr. ☐Mrs. ☐Rev. ☐Ms. ☐Miss. ☐Dr. | Last Name | First Name | Middle Name |
| ☐Female ☐Male ☐Transgender | DOB / / | Social Security # | Preferred Name |
| Mailing Address | Apt. # | P.O. Box # | City |
| | State | | Zip Code |
| Email | Home Phone # (with area code) | Work Phone # (with area code and ext.) | Mobile/Other Phone # (with area code) |
| Preferred Phone Number to Contact Patient ☐Home ☐Work ☐Mobile | Please contact me by (Please check all that apply) ☐Phone ☐Email ☐Text | | |

## EMERGENCY CONTACT INFORMATION (Required by law)

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Name | |
| Relationship | Home Phone # (with area code) | Other Phone # (with area code) | Email |
| Mailing Address | City | State | |
| | Zip Code | | |

## BILLING ADDRESS

☐Same as above Mailing Address

| | | |
|---|---|---|
| Billing Address | City | State |
| | Zip Code | |

## RESPONSIBLE PARTY INFORMATION

☐Same as Patient

| | | | |
|---|---|---|---|
| Last Name | First Name | Middle Name | |
| Relationship to patient | Social Security # | DOB / / | Email |
| Mailing Address | City | State | |
| | Zip Code | | |
| Home Phone # (with area code) | Mobile/Other Phone # (with area code) | | |

## ADDITIONAL INSURANCE

If you are covered by a second dental insurance program through your spouse or other person, please provide that information below:

| | | |
|---|---|---|
| Insured Name | DOB / / | |
| Address | ID Number | Insurance Company |
| | Relationship to Insured | |

## PATIENT DEMOGRAPHICS

The following optional information is collected to better the demographics of our patient population

Ethnicity ☐White/Caucasian ☐Asian ☐Hispanic ☐Black/African American ☐Other

Language Preference ☐English ☐Spanish ☐Other

Contact me: ☐Text Message ☐Email

In additional to contacting me by US Mail or telephone, I authorize Nevada Dental Benefits, Ltd. to contact me by the methods indicated above, to advise me of appointments, treatment needs and other information related to my care.

_____ Signature

_____ Date mm/dd/yy