BEAUFORT CENTER FOR DENTISTRY

1264 Ribaut Road, Ste. 401, Beaufort, SC 29902
(843) 524-7950

Thank you for choosing Beaufort Center for Dentistry! We strive to provide you with the best dental care. To help us meet your needs, please fill out this form completely in ink. Your answers are for our records only and will be kept strictly confidential. If you have any questions or need assistance, please do not hesitate to ask a team member!

New Patient Registration Form

Prefix:____ First Name:_____ Middle Name:_____ Last Name_____ Suffix:___
Preferred Name:_____ Date of Birth: _____ SSN:_____
Driver's License Number: _____ Sex: ☐ Male ☐ Female
Marital Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address: _____
City_____ State _____ Zip_____
Home Phone: _____ Mobile Phone: _____
Employer: _____ Occupation: _____
Work Phone: _____
Email Address: _____ ☐ Consent for Digital Communications
Preferred Contact Method for Appointment Confirmation: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Text ☐ Email
How did you learn about our practice? ☐ Google ☐ Facebook ☐ Yelp ☐ Mailer ☐ Word of Mouth/Friend
If you were referred by a friend, whom may we thank? _____

Responsible Party:
Are you the Responsible Party? ☐ Yes ☐ No ***If no, please fill out the information below.***
First Name: _____ Middle Name: _____ Last Name: _____
Preferred Name:_____ Date of Birth: _____ SSN:_____
Mailing Address: _____
City_____ State _____ Zip_____
Home Phone: _____ Cell Phone: _____
Email Address: _____
Relationship to patient:_____

Insurance Information:
Name of Insurance Carrier: _____ Group#:_____
Relationship to Insured: _____
Insured SSN: _____ Insured Date of Birth: _____
Insured Employer: _____

Do you have secondary coverage? *If yes, please fill out the information below.*

Secondary Insurance Information:
Name of Insurance Carrier: _____ Group#:_____
Relationship to Insured: _____
Insured SSN: _____ Insured Date of Birth: _____
Employer: _____