

Harmony Patient PRE-Registration Form

General Information:

Today's Date: _____

First name: _____ Last name: _____

Preferred Name/Pronouns _____

Date of Birth: ____/____/____

Phone: _____

Address: _____

Apt/Unit # _____

City: _____ State: _____ Zip: _____

How did you hear about us? _____

Dental Insurance Status

I am uninsured

I have dental insurance

Member/Subscriber ID #: _____

Subscriber's First and Last Name: _____

Relationship to Subscriber: _____

Subscriber's Date of Birth: ____/____/____

State in which the Insurance Carrier is located: _____

Name of insurance company: _____

Insurance Carrier Phone Number: _____

I am interested in:

A consultation

Dental cleaning

Dental Concerns: _____
