Houston (713) 347-6833
Dallas (214) 550-7323

Info@mobiledentalassociates.com
(713) 347-6844

NEW PATIENT REGISTRATION

Welcome to Mobile Dental Associates! We are excited to have you/your loved one join our family of patients! The following information is needed to be able to provide our patients with the quality care they should expect and deserve from a Mobile Dental Team. Please be as thorough as possible and if you have any questions feel free to call us or send us an email, we would be happy to help.

PATIENT INFORMATION

Where Does The Patient Currently Reside? (Please check only one)

☐ Private Residence ☐ Senior Living ☐ Assisted Living ☐ Independent Living ☐ Memory Care ☐ Skilled Nursing ☐ Group Home

Patient Name: ____________________ ___ ________________________ ___________________ _________________
First M.I. Last Nickname DOB

_________________________________ _____________ **Marital Status:** ☐ Married ☐ Widowed ☐ Single **Gender:** ☐ M ☐ F
If Applicable.....Name of Patient's Community Patient's Room #

Address:____

____

Cell Phone #:(____) _______ - ______________ Email:____

City: ____ State:______________ Zip Code: ________________

Emergency/Alternate Contact:______________________________ Cell Phone #:(___) _______ - ___________

INFORMATION ABOUT THE PERSON WHO IS COMPLETING THIS FORM (IF NOT THE PATIENT)

Name:_____________________________ _______________________________________ _______________
First Last DOB

Street Address:____

City:____________________________________ State:______________ Zip Code:_______________________

Cell Phone #:(_____) ________ - _____________ Email:____

SIGNATURES

______________________________________ ____________________________________ _______________
Patient's Signature(If Applicable) Patient's Name (Please Print) Date

______________________________________ ____________________________________ _______________
Signature (If other than patient) (Please Print Signer's Name) Date

Signer's Legal Authority? ☐ Patient(self) ☐ Responsible Party ☐ Guardian ☐ Power of Attorney ☐ Conservator ☐ __________

Signer's Relationship To Patient? ☐ Patient(self) ☐ Daughter ☐ Son ☐ Spouse ☐ Mother ☐ Father ☐ __________