

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1. If this appointment is for you start here			
Date			
Last Name	First Name	MI	
Prefers to be called			
Address			
City	State	Zip	
Home Phone No.	Fax		
Cell	Email		
Birthdate	Age	Male	Female
Married	Single	Divorced	Widowed
Social Security No.			
If this appointment is for your child start here			
Date			
Last Name	First Name	MI	
Address			
City	State	Zip	
Home Phone No.	Fax		
Birthdate	Age	Male	Female
School	Grade		
Social Security No.			
2. Dental Insurance			
Primary Carrier			
Insurance Company			
Group No.			
Employer Name			
Insured's Name			
Date of Birth		Relationship to Patient	
Insured's ID No.			
Insured's Social Security No.			
3. Getting to know you			
Is another member of your family or relative a patient at our office?			
Name:		Relationship	

You were referred to us by		
Your former address		
City	State	Zip
Person to contact for emergency		
Phone number		
Address		
City	State	Zip
Closest Relative not living with you		
Phone number		
Address		
City	State	Zip
4. Account Information		
Person Financially Responsible for Account		
Name		
Relation to patient		Social Security No.
Address		
City	State	Zip
Phone No.		
You		
Name		
Occupation		
Employer's Name		
Address		City
Phone No.		Fax No.
Your Spouse		
Name		
Occupation		
Employer's Name		
Address		City
Phone No.		Fax No.