PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Date _____

First Middle Last Preferred

Patient's Birthdate ____/____/____ Social Security Number _____-_____-_____

SINGLE___ MARRIED ___ SEPARATED ___ WIDOWED ___ DIVORCED ___ Email Address _____

This may be used to confirm dental appointments

Home Address _____

Street City State Zip

Home Telephone _____ Work Telephone _____ Cell Phone _____

Patient's Occupation _____ Patient's Employer _____

Business Address _____

Street City State Zip

Spouse or Parent's Name (if patient is a minor) _____

First Middle Last Preferred

Spouse or Parent's Birthdate: _____/_____/_____ Spouse or Parents Contact Number(s)_ _____

Spouse or Parent's Occupation _____ Employer _____

Business Address _____

Street City State Zip

In case of an Emergency, please contact _____

Home Phone _____ Cell Phone _____ Work Phone _____

Whom may we thank for recommending you to our practice? _____

Who is responsible for this account? _____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name _____

Employee Date of Birth _____

Employer Insurance Company _____

Policy/ Member ID No. _____

Group No. _____

Ins. Co. Phone Number _____

SECONDARY COVERAGE

Employee Name _____

Employee Date of Birth _____

Employer Insurance Company _____

Policy/ Member ID No. _____

Group No. _____

Ins. Co. Phone Number _____

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for a credit.

Patient's Signature _____ Today's Date _____