PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

1

DATE

LAST NAME | FIRST | M.I.

PREFERS TO BE CALLED BY

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 | M.I.

ADDRESS

CITY | STATE | ZIP

HOME PHONE NO.

BIRTHDATE | AGE | MALE | FEMALE

SCHOOL | GRADE

SOCIAL SECURITY NO.

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

2 DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. NO.

INSURED'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

GROUP NO.

EMPLOYER NAME

INSURED'S NAME

DATE OF BIRTH | RELATIONSHIP TO PATIENT

INSURED'S I.D. 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

RELATIONSHIP 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.