PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT INFORMATION

DATE

PATIENT NAME

ADDRESS

CITY STATE ZIP

HOME PHONE NO.

E-MAIL:

BIRTHDATE SEX AGE

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED_____

PATIENT'S SOCIAL SECURITY NO.

DRIVER'S LICENSE NO. & STATE

OCCUPATION

EMPLOYER

BUSINESS ADDRESS

CITY STATE ZIP

BUSINESS PHONE NO. EXT.

BUSINESS FAX

SPOUSE'S NAME

SPOUSE'S OCCUPATION

SPOUSE'S EMPLOYER

SPOUSE'S BUSINESS ADDRESS

CITY STATE ZIP

SPOUSE'S BUSINESS TELEPHONE EXT.

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

_____ CHECK HERE IF SAME AS FIRST PERSON LISTED AT LEFT

NAME

HOME ADDRESS

CITY STATE ZIP

BUSINESS NAME

BUSINESS ADDRESS

CITY STATE ZIP

HOME PHONE BUSINESS PH.

BUSINESS PHONE NO. EXT.

PERSON TO CONTACT FOR EMERGENCY

PHONE NO.

ADDRESS

CITY STATE ZIP

CONTACT OUT OF HOUSEHOLD FOR EMERGENCY

NAME

PHONE NO.

ADDRESS

CITY STATE ZIP

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY

CLAIM FILING ADDRESS

PHONE

EMPLOYEE NAME

GROUP OR PLAN NO.

DATE OF BIRTH (INSURED)

EMPLOYEE'S SOCIAL SECURITY NO.

SECONDARY CARRIER

INSURANCE COMPANY

CLAIM FILING ADDRESS

PHONE

EMPLOYEE NAME

GROUP OR PLAN NO.

DATE OF BIRTH (INSURED)

EMPLOYEE'S SOCIAL SECURITY NO.

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY

OR A RELATIVE A PATIENT AT OUR OFFICE?

THEIR NAME

WHO REFERRED YOU TO OUR PRACTICE?

X _____

SIGNATURE OF RESPONSIBLE PARTY

____ PATIENT _____FATHER (or husband) ____ MOTHER (or wife)____ GUARDIAN