

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

1

DATE _____

LAST NAME FIRST M.I.

PREFERS TO BE CALLED BY _____

ADDRESS _____

CITY STATE ZIP

HOME PHONE NO. _____

BIRTHDATE AGE MALE FEMALE

MARRIED SINGLE DIVORCED WIDOWED

SOCIAL SECURITY NO. _____

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

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

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. _____

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. _____

other contacts:
email: _____
cellphone: _____

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

Please turn over and sign