

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. FAX

CELL EMAIL

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 THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

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.

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.

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