

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name _____ Date _____

First Middle Last

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

Child Single Married Separated Widowed Divorced

Home Address _____

Street City State Zip

Home Telephone _____ Work Telephone _____ Pager/Cell Ph. _____

Optional

Patient's Occupation _____ Hours Worked _____ to _____ E Mail Add. _____

Optional

Patient's Employer/School _____ Full Time College/University Student? Yes No

Business or School Address _____

Street City Zip

Spouse's or Guardian's Name _____

First Middle Last

Spouse's or Guardian's Birthdate _____ Social Security Number _____ - _____ - _____

Spouse's or Guardian's Occupation _____ Hours Worked _____ to _____

Spouse's or Guardian's Employer _____ Work Telephone _____

Business Address _____

In case of an Emergency, please contact _____

Home Phone _____ Work Phone _____

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

Name of Person responsible for this account? _____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name _____

Employer _____

Insurance Co. _____

Policy Number _____

Group Number _____

Insurance Co. Phone No. _____

SECONDARY COVERAGE

Employee Name _____

Employer _____

Insurance Co. _____

Policy Number _____

Group Number _____

Insurance Co. Phone No. _____

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 credit.

Patient or Guardian's Signature _____ Today's Date _____