PATIENT REGISTRATION

Today's Date ____________________

Patient's Name ____________________ Sex: M F Birthdate ____________ Age ______

Home Address ____________________ City ____________ State ______ Zip ______

Please Circle One: Single Married Separated Widow Your Soc. Sec. # ____________

Home Ph. # ____________ Cell Ph. # ____________ E-mail Address ____________

Your Employer ____________________ Work Ph. # ____________ How Long Employed ______

Are you a full time student? ☐ Yes ☐ No If so, where? ____________________

If patient is minor, we need: Mother's DOB ____________ Father's DOB ____________

Person responsible for account ____________ DOB ____________ Driver's License # ____________ Relationship ____________

Name of spouse (parent if minor) ____________________ Spouse's (parent's) Soc. Sec. # ____________

Address ____________________ City ____________ State ______ Zip ______

Spouse's (parent's) Employer ____________________ Work Ph. # ____________ Cell Ph. # ____________

EMERGENCY INFORMATION
Name, address & telephone of a relative not living with you.
____

____

Dental concerns you wish to discuss today? ____________________

How did you hear about our office? ( ) Referral ( ) Sign ( ) Yellow Pages ( ) Google ( ) Facebook ( ) Website

DENTAL INSURANCE INFORMATION (Primary Carrier)

Insured's Name ____________________ Relationship to Patient ____________

Insured's Employer ____________________

Insurance Co. ____________________

Insurance Co. Address ____________________

Phone # ____________________ DOB ____________

SS# ____________ Group # ____________ Local # ____________