PATIENT REGISTRATION

"Welcome! So that we may provide you with the best possible care, please complete this registration form. All information is completely confidential.

DATE					
PATIENT'S LAST NAME		FIRST		M.I.	
PREFERS TO BE CALLED BY					
ADDRESS					
CITY		STATE		ZIP	
HOME PHONE NO.		WORK NUMBER		EXT.	
CELL		EMAIL			
BIRTHDATE	AGE	MALE	FEMALE		
SINGLE MARRIED	SEPARATED	DIVORCED	WIDOWED		
SOCIAL SECURITY NO.					
OCCUPATION					
EMPLOYER'S NAME					
EMPLOYER'S ADDRESS			CITY		

ACCOUNT INFORMATION

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

If same as above check here . ☐

LAST NAME	FIRST	M.I.
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	WORK NUMBER	EXT.
BIRTHDATE	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME: RELATIONSHIP:

WHOM MAY WE THANK FOR REFERRING YOU?

DENTAL INSURANCE

PRIMARY CARRIER

INSURANCE COMPANY	
INSURANCE COMPANY ADDRESS	
INSURANCE COMPANY PHONE NUMBER	
INSURED’S EMPLOYERS NAME	
GROUP NO.	
INSURED'S NAME	
INSURED'S DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S SOCIAL SECURITY NO	

SECONDARY CARRIER

INSURANCE COMPANY	
INSURANCE COMPANY ADDRESS	
INSURANCE COMPANY PHONE NUMBER	
INSURED'S EMPLOYERS NAME	
GROUP NO.	
INSURED'S NAME	
DATE OF BIRTH	RELATIONSHIP TO PATIENT
INSURED'S SOCIAL SECURITY NO.	

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME		
PHONE NUMBER		RELATIONSHIP
ADDRESS		
CITY	STATE	ZIP