PATIENT REGISTRATION FORM

(This information is necessary for our files and your health, it will be considered CONFIDENTIAL)

PATIENT INFORMATION

First Name | Middle Name | Last Name | Male/Female

Home Address | City | Zip | How Long?

Home Telephone ( ) | Cell Phone ( ) | Email: | Date of Birth | Age

Social Security No. | Occupation | Business ( ) Telephone ext

Employer | Address | City

Are you a full time student? Where: | Whom may we thank for referring you?

Previous Dentist | Street | City | Telephone

PARENT/SPOUSE INFORMATION

First Name | Middle Initial | Last Name

Home Address (if different) | City | Zip

Home Telephone ( ) | Date of Birth | Social Security No.

Employer | Address City | Zip | Business ( ) Telephone ext.

DENTAL INSURANCE INFORMATION

Your insurance is a legal contract between you and your company. As a courtesy your insurance forms will be speedily processed.
Some insurance plans do not provide full coverage for your dental treatment. Please remember that you are responsible for payment of your account.

Insured Person | Relationship to Patient | Date of Birth

Insurance Carrier | Address | Phone ( )

Group Number | Social Security No. | Employer: (If different than Patient or Resp. Party) | Business Phone ( )

Insured Person | Relationship to Patient | Date of Birth

Insurance Carrier | Address | Phone ( )

Group Number | Social Security No. | Employer: (If different than Patient or Resp. Party) | Business Phone ( )

EMERGENCY INFORMATION

In case of emergency call: (Nearest relative not living with you) | Relationship

Home Telephone ( ) | Business Telephone ( )

Name of Patient's Physician | Phone ( )

The Above Information is Correct
Patient Signature | Date

(PLEASE COMPLETE REVERSE SIDE)