

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

|                         |        |          |         |          |
|-------------------------|--------|----------|---------|----------|
| DATE                    |        |          |         | <b>1</b> |
| 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.     |        |          |         |          |

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

|                     |     |       |        |  |
|---------------------|-----|-------|--------|--|
| DATE                |     |       |        |  |
| LAST NAME           |     | FIRST | M.I.   |  |
| ADDRESS             |     |       |        |  |
| CITY                |     | STATE | ZIP    |  |
| HOME PHONE NO.      |     |       |        |  |
| BIRTHDATE           | AGE | MALE  | FEMALE |  |
| SCHOOL              |     | GRADE |        |  |
| SOCIAL SECURITY NO. |     |       |        |  |

IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

|                               |                         |          |
|-------------------------------|-------------------------|----------|
| DENTAL INSURANCE              |                         | <b>2</b> |
| 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. |                         |          |

|  |                     |          |
|--|---------------------|----------|
| ACCOUNT INFORMATION                        |                     | <b>4</b> |
| 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.             |          |

|   |               |          |
|---|---------------|----------|
| GETTING TO KNOW YOU   |               | <b>3</b> |
| 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      |