

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

<b>1</b>			
DATE			
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.			
DATE			
LAST NAME		FIRST	M.I.
ADDRESS			
CITY		STATE	ZIP
HOME PHONE NO.		FAX	
BIRTHDATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

IF THIS APPOINTMENT IS FOR YOU START HERE

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE

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

<b>2</b>	
DENTAL INSURANCE	
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.	

<b>4</b>	
ACCOUNT INFORMATION	
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.

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