PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS **APPOINTMENT IS FOR YOU START HERE**

IF THIS **APPOINTMENT IS** FOR YOUR CHILD START HERE

1			
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.			
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 2	
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 4		
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 3		
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

Please turn over and sign