

WELCOME TO OUR DENTAL PRACTICE! PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING. THIS INFORMATION IS CONFIDENTIAL

IF THIS APPOINTMENT IS FOR YOU START HERE		
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
MARITAL STATUS	Single Married Widowed Divorced	
SOCIAL SECURITY NO.		

IF THIS APPOINTMENT IS FOR YOUR CHILD START HERE		
DATE		
LAST NAME	FIRST	M.I.
PREFERS TO BE CALLED BY		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.	FAX	
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		
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		
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		
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	
ADDRESS	CITY	STATE ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU	PHONE	
ADDRESS	CITY	STATE ZIP