PATIENT REGISTRATION
PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

Patient's Name_____ **Date**_____
First Middle Last
Patient's Birthdate_____ **Social Security Number**_____-_____-_____

Child _____ **Single** _____ **Married** _____ **Separated** _____ **Widowed** _____ **Divorced** _____

Mailing Address_____
Street City State Zip
Home Telephone_____ **Work Telephone**_____ **Pager/Cell Ph.**_____
Optional
Patient's Occupation_____ **Hours Worked**_____ **to**_____ **E Mail Add.**_____

Patient's Employer/School_____ **Full Time College/University Student? Yes**____ **No** _____

Business or School Address_____
Street City Zip

Spouse's or Guardian's Name_____
First Middle Last
Spouse's or Guardian's Birthdate_____ **Social Security Number**_____-_____-_____

Spouse's or Guardian's Occupation_____ **Hours Worked**_____ **to**_____

Spouse's or Guardian's Employer_____ **Work Telephone**_____

Business Address_____

In case of an Emergency, please contact_____

Home Phone_____ **Work/Cell Phone** _____

Whom may we thank for recommending you to our office?_____

Name of Person responsible for this account?_____

DENTAL INSURANCE

PRIMARY COVERAGE

Employee Name_____

Employer_____

Insurance Co._____

Policy Number_____

Group Number_____

Insurance Co. Phone No._____

SECONDARY COVERAGE

Employee Name_____

Employer_____

Insurance Co._____

Policy Number_____

Group Number_____

Insurance Co. Phone No._____

The information I have provided is complete and accurate to the best of my knowledge. I consent to whatever procedures are deemed necessary to diagnose my oral condition. I agree to be responsible for payment of all services rendered. I authorize a credit check should I ask for credit.

Patient or Guardian's Signature_____ **Today's Date**_____