PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

IF THIS APPOINTMENT IS FOR YOU START HERE

DATE _____
NAME _____
PREFERS TO BE CALLED _____
ADDRESS_____
CITY _____STATE _____ ZIP _____
HOME PHONE NO. _____
CELL PHONE NO. _____FAX _____
E-MAIL _____
BIRTHDATE _____ AGE _____
SOCIAL SECURITY NO. _____

IF THIS APPOINTMENT IF FOR YOUR CHILD START HERE

DATE_____
NAME _____
PREFERS TO BE CALLED _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE NO. _____
BIRTHDATE _____ AGE _____
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

COMPANY _____
GROUP NO. _____
EMPLOYER _____
INSURED'S NAME
_____
INSURED'S D.O.B_____
RELATION TO PATIENT
_____
INSURED'S I.D NO.
_____
INSURED'S SSN _____

SECONDARY CARRIER

COMPANY _____
GROUP NO. _____
EMPLOYER _____
INSURED'S NAME
_____
INSURED'S D.O.B _____
RELATION TO PATIENT
_____
INSURED I.D'S NO.
_____
INSURED'S SSN _____

ACCOUNT INFORMATION

PERSON FINACIALLY RESPONSIBLE FOR ACCOUNT

NAME_____
RELATION TO PATIENT _____
SSN _____
ADDRESS _____
CITY _____
STATE _____ ZIP _____
PHONE _____

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
_____
PERSON TO CONTACT FOR EMERGENCY
NAME _____
PHONE NO. _____
ADDRESS _____
CITY _____
STATE _____ ZIP _____
RELATIONSHIP _____