

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 IS 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 FINANCIALLY 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 _____	