

RIVERSIDE DENTAL, P.C.

Patient Information

Name _____ Preferred Name/Nickname _____
First MI Last

Address _____ City _____ State _____ Zip _____

E-Mail _____ Cell Phone _____ Home Phone _____

SS# _____ Birthdate _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

If College Student, F.T. / P.T., Name of School _____ City _____ State _____

Patient's or Parent's/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship To Patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____ SS# _____

Employer _____ Work Phone _____

Is this person currently a patient in our office Yes No

Dental Insurance Information

Name of Insured _____ Relationship To Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp # _____ Policy / I.D. # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Do you have any additional dental insurance? Yes No If yes, complete the following:

Name of Insured _____ Relationship To Patient _____

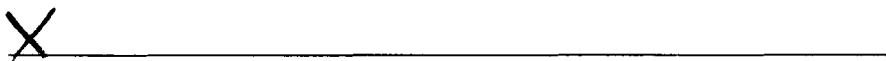
Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Co. _____ Tel. # _____ Grp # _____ Policy / I.D. # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

 _____ Date _____
Signature of Patient or Parent/Guardian if minor

CONFIDENTIAL REGISTRATION