

WELCOME!
PATIENT REGISTRATION INFORMATION

LAST NAME _____ FIRST _____ MI _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL _____ EMAIL _____

PATIENT BIRTH DATE _____ AGE _____ FEMALE MALE

PATIENT SSN _____

How did you hear about us?

Phonebook Website Billboard Radio Friend (name) _____

How would you like us to confirm your appointments?

Phone - home, work or cell (please circle) Text message via cell phone Email

PATIENT'S EMPLOYER _____

WORK ADDRESS _____

WORK PHONE _____

EMERGENCY CONTACT _____ PHONE _____

RELATIONSHIP TO PATIENT _____

PARENTS' NAMES (if above is a minor) _____

If parent/guardian is not present at child's appointment, number he/she can be reached at
immediately (if needed during appointment) _____

SSN MOTHER _____ SSN FATHER _____

PARENT'S EMPLOYER _____

WORK ADDRESS _____

WORK PHONE _____

INSURANCE INFORMATION

DENTAL INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

INSURANCE CO. PHONE _____ GROUP # _____

SUBSCRIBER NAME _____ BIRTHDATE _____

RELATIONSHIP TO PATIENT _____

SUBSCRIBER ID# OR SSN _____

COVERAGE: SELF _____ SPOUSE _____ FAMILY _____

(Please complete other side)

