

## PATIENT REGISTRATION

**PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION**

IF THIS APPOINTMENT IS FOR YOU, START HERE	DATE <span style="float: right;">1</span>			
	LAST NAME		FIRST	M.I.
	PREFERS TO BE CALLED BY			
	ADDRESS			
	CITY		STATE	ZIP
	HOME PHONE NO.			
	BIRTHDATE	AGE	MALE	FEMALE
	MARRIED	SINGLE	DIVORCED	WIDOWED
	SOCIAL SECURITY NO.		EMAIL ADDRESS	
	DATE			
LAST NAME		FIRST	M.I.	
ADDRESS				
CITY		STATE	ZIP	
HOME PHONE NO.				
BIRTHDATE	AGE	MALE	FEMALE	
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.				

<b>DENTAL INSURANCE</b>		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		

<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS		CITY
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS		CITY
PHONE NO.	FAX NO.	

<b>GETTING TO KNOW YOU</b>		<b>3</b>
IS ANOTHER MEMBER OF YOUR FAMILY OR A RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
YOU WERE REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NO.		
ADDRESS		
CITY	STATE	ZIP