Patient Registration

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Patient Information

Name _____ Today's Date ____/____/____

Address _____ Home Phone ( ) ____ - ____

City _____ State ____ Zip ____ Cell Phone ( ) ____ - ____

Date of Birth ____/____/____ Age ____ ☐ Male ☐ Female Work Phone ( ) ____ - ____

Are you: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Primary Number: ☐ Home ☐ Cell ☐ Work

Email _____ Social Security No. ____ - ____ - ____

OK to text you for confirming your appointment, etc? ☐ Yes ☐ No

OK to e-mail you for confirming your appointment, etc? ☐ Yes ☐ No

Referral Information

☐ General Dentist ☐ Family/Friend

☐ Dental Specialist ☐ Other Patient

☐ Physician ☐ Internet

Name _____

Date of Referral ____/____/____ Phone Number ( ) ____ - ____

Address _____

City _____ State ____ Zip ____

Dental Insurance

Insured's Name _____ Name of Employer _____

Insurance Company _____ Group No. _____

Insured's I.D. No. _____ Insured's Social Security No. ____ - ____ - ____

Relationship to Patient _____ Date of Birth ____/____/____

Getting to Know You

Is another member of your family a patient at our office?

Name _____ Relationship _____

Person to Contact in case of an Emergency

Name _____ Relationship _____ Phone Number ( ) ____ - ____

Address _____ City _____ State ____ Zip ____

Please complete consent on back page