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Patient Registration Form

Welcome and thank you for selecting our office. Please take a few minutes to fill out this form as complete as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

1. PATIENT INFORMATION:

- Today's Date _____
- Patient's Social Security # _____-_____-_____
- Patient's Last Name_____ Patient's First Name_____ M. I. _____
- Address _____ City_____ State _____ Zip _____
- Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
- Sex: ☐ **Male** ☐ **Female;** Age _____ Date of Birth: ____-_____-_____ Home Phone # (_____) _____-_____
- Patient's Employer _____ Work Phone # (_____) ____-_____ext. ___ Cell Phone # (_____) _____-_____
- Employer's Address _____ City _____State _____ Zip _____
- Spouse's Name _____ Employer _____ Work Phone # (_____) _____-_____
- If Patient is a Student, Name of School/College _____City_____ State _____
- **PERSON TO CONTACT IN CASE OF EMERGENCY** _____ Phone # (_____) _____-_____
- How did you find us? _____

2. RESPONSIBLE PARTY (If different from patient):

- Name of Person Responsible for this Account _____ Relationship _____
- Address _____ Home Phone # (_____) _____-_____
- Driver License # _____ Employers _____ Work Phone # (_____) _____-_____
- Currently a Patient in our Office: ☐ Yes ☐ No

3. DENTAL INSURANCE INFORMATION:

- Name of Subscriber _____ Relationship to Patient _____
- Subscriber's Birthday _____ Subscriber's Social Security # _____
- Employer's Name _____ Work Phone # (_____) _____-_____
- Employer Address _____ City _____State _____ Zip _____
- Insurance Company_____ Contact # _____
- Address _____ City _____ State _____ Zip _____

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

4. ADDITIONAL DENTAL INSURANCE:

- Name of Subscriber _____ Relationship to Patient _____
- Subscriber's Birthday _____ Subscriber's Social Security # _____
- Employer _____ Work Phone # (_____) _____-_____
- Employer Address _____ City_____ State _____ Zip _____
- Insurance Company _____ Contact # _____
- Address _____ City _____ State _____ Zip _____