PATIENT REGISTRATION

Today's Date____/____/____

Name____ Preferred Name _______________
Last First Initial

[__] Female [__] Male
[__] Single [__] Married [__] Divorced Social Security #______-______-_______ Date of Birth ____/____/____

If Patient is a Minor:
Parent's or Guardian's Name _________________________________ Social Sec. #______-______-_______
Last First Initial

Residence Address ____
Street City State Zip

Phone Numbers (include area code):

Home________________Work_______________Cell_______________ Email address________________________________

Please *circle* the best way to contact you: Home Work Cell Email

Is it okay to leave a detailed message? _____ Yes _____ No

Employer ______________________________ Occupation______________________

How did you hear about our office? (Please check and describe)
[__] Yellow Pages [__] Insurance Company [__] Referred by__________________________ [__] Other ______________________

If other members of your family are already patients here please list their names:

____

Name of Emergency Contact (*someone not living with you*) ____

Relationship_______________________________________ Contact's Telephone Number __________________________

Purpose of Today's Visit____

Method of Payment [__] Cash [__] Credit Card [__] Insurance

If you have dental insurance, please complete the following so we may assist you in processing your claim. If you have an insurance card for us to copy, ***you need to fill out only the information not listed on the card.***

DENTAL INSURANCE INFORMATION

If married, does your spouse have different dental coverage? [_] Yes [_] No If yes, complete for both plans

	Primary Coverage	Secondary Coverage
Name of Insurance Company	____________	____________
Insurance Company Address	____________	____________
Insurance Company Telephone	____________	____________
Subscriber's Name	____________	____________
Subscriber's Social Security #	____________	____________
Subscriber's Date of Birth	____________	____________
Address (if different from above)	____________	____________
Employer Name/Group #	____________	____________