Patient Registration

Patient

Name: _____ Preferred Name: _____
Last First MI
Mailing Address:_____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Cell Phone: _____ Email: _____

Married Status: □ Married □ Single □ Divorced □Widowed Sex: □ Male □ Female

Social Security Number: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Emergency contact: (Name/number) _____

Responsible Party (required for patients under 18 or if the responsible party is someone other than the patient)

Name: _____ Relationship to patient: _____
Last First MI
Address: _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Social Security Number: _____ Date of Birth: _____

Dental Insurance Policy Holder Information

Name of Policy Holder: _____ Date of Birth: _____

ID# _____ Group Number: _____ Employer: _____

Insurance Company: _____ Phone Number: _____

Address: _____ City, State, Zip: _____
You are financially responsible for all treatment provided including any procedure not covered or paid by your insurance. We accept cash/check, MasterCard, Visa , Discover and CareCredit.

The information on this page is correct to the best of my knowledge. I will inform you of any changes.

X _____ Date: _____ □ Patient □ Responsible Party