PATIENT INFORMATION

Name_____ _____
Last First M.I. Preferred Name or Title

◯Single ◯Married ◯Divorced ◯Widowed ◯Male ◯Female Height_____ Weight_____

Home Address_____
City Zip

Patient Employed By_____ Occupation_____

Business Address_____
City Zip

Birth date_____/_____/_____ Age_____ Soc. Sec. No._____-_____-_____ Driver's Lic. No._____

When Was Your Last Visit To A Dentist_____ Reason_____

Whom May We Thank For Referring You To Our Office?_____ Relationship_____

Reason For Visit_____

CONTACT INFORMATION

Home Phone_____ Work Phone_____ Ext._____

Cellular Phone_____ Pager_____

Email_____@_____ How Often Do You Check Email?_____

FAMILY INFORMATION

◯Spouse ◯Parent: Name_____ Is Spouse /Parent a Patient In Our Office? ◯Yes ◯No
Last First

Home Address: ☐Same As Above Or:_____ Home Phone_____

Business Address_____ Work Phone_____

Spouse / Parent Employed By_____Occupation_____

INSURANCE INFORMATION

Insured's Name_____ Soc. Sec. No._____/_____/_____

Insurance Company_____ ☐Dental Coverage ☐Medical Coverage

Insurance Company Address_____ City_____ State_____ Zip_____

Policy No._____ Group No._____ Local_____ Other_____

*** * * DO YOU HAVE DUAL (SECONDARY) INSURANCE COVERAGE? ◯Yes ◯No**

Insured's Name_____ Soc. Sec. No._____/_____/_____

Insurance Company ☐Dental Coverage ☐Medical Coverage

EMERGENCY INFORMATION

LOCAL PERSON TO CONTACT OUTSIDE IMMEDIATE FAMILY IN CASE OF AN EMERGENCY

Name_____ Relationship_____

Address_____ City_____ Home Phone_____

I understand that I am responsible for payment for dental services provided in this office for me and my dependents. I further understand that a finance charge will be added to any overdue balance. The above information is correct to the best of my knowledge.

Patient / Parent Signature_____ Date_____/_____/_____

*Please type your name in the signature field to enact your signature.

PATIENT REGISTRATION