PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

TMENT
OU
ERE

1

DATE		
NAME		
SPOUSE		
ADDRESS		
CITY	STATE	ZIP
HOME PHONE NO.		
BIRTHDATE	AGE	MALE ☐ FEMALE ☐
MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐		
SOCIAL SECURITY NO.		

TMENT
OUR
TART

DATE		
NAME		
ADDRESS		
CITY		
HOME PHONE NO.		
BIRTHDATE	AGE	UNION OR LOCAL NO.
SCHOOL		
SOCIAL SECURITY NO.		

If your child's last name and/or address are not the same as yours. Fill in the top box also.

DENTAL INSURANCE 2

PRIMARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
UNION OR LOCAL NO.	
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

SECONDARY CARRIER

INSURANCE COMPANY	
GROUP NO.	
EMPLOYEE	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYEE NO.	
EMPLOYEE SOCIAL SECURITY NO.	

GETTING TO KNOW YOU 3

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME:	RELATIONSHIP	
REFERRED TO US BY		
YOUR FORMER ADDRESS		
CITY	STATE	ZIP
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
CLOSEST RELATIVE NOT LIVING WITH YOU		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

ACCOUNT INFORMATION 4

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

NAME		
RELATIONSHIP TO PATIENT		
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
EMAIL ADDRESS		

YOU

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADRESS	CITY
BUSINESS PHONE NO.	EXT.

YOUR SPOUSE

NAME	
OCCUPATION	
EMPLOYER	
BUSINESS ADDRESS	CITY
BUSINESS PHONE NO.	EXT.