PATIENT REGISTRATION

Last Name _________________________ **First Name** _____________________ **Middle Initial** _______

Preferred Name __________________________ **Marital Status** ___________________________

Address _________________________________ **Home Phone** ____________________________

City, State _______________________________ **Work Phone** _____________________________

Zip Code ________________________________ **Cell Phone** ______________________________

Email Address ____________________________

Birth Date _______________________________ **Social Security Number** ___________________

Employment Status ________________________ **Student Status** ___________________________

Occupation ______________________________ **Employer** _______________________________

Person Responsible for Payment (If someone other than patient) _______________________________

Address ____

Emergency Contact ___________________________ **Relationship to Patient** ____________________
Phone ___________________________________

Family Physician _____________________________ **Date of Last Medical Exam** ________________

Previous Dentist _____________________________ **Date of Last Dental Exam** _________________

How Did You Hear About Us? **What is the Purpose of Your Visit?**

____ ____

Please Indicate Below How You Prefer to Pay for Your Dental Treatment

Cash __ **Personal Check** __ **Credit Card** __ **Dental Insurance** __

Name of Insured ______________________________ **Relationship to Patient** _____________________

Insured Social Security Number _________________ **Insured Date of Birth** _______________________

Employer ___________________________________ **Name of Insurance Company** ________________

Group Number ________________________________ **Policy Number** ____________________________

Other Insurance ______________________________