Patient Registration

Whom may we thank for referring you? _____

Patient Name: _____
(First) (M.I.) (Last)

Preferred Name: _____ Sex: ☐ M ☐ F

Date of Birth: _____ Employment: _____

SSN: _____ _____

Address: _____

_____

Home Phone: _____

Work Phone: _____ Email: _____

Cell Phone: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Responsible Party (if other than patient)

Name: _____
(First) (M.I.) (Last)

Address (if different than above)

_____

_____

Date of Birth _____ SSN: _____

Home Phone: _____ Email: _____

Work Phone: _____

Cell Phone: _____

Insurance Information:

Name of Insured: _____ Relationship to Patient: _____

Insured SSN: _____ Insured DOB: _____

Employer: _____ Insurance Company: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Miscellaneous Information

Previous Dentist: _____ Date of last visit: _____

Reason for leaving previous dentist: _____

Date of most recent dental x-rays: _____

Preferred pharmacy: _____

Emergency Contact: _____ Contact #: _____