PATIENT REGISTRATION

PATIENT NAME _____ BIRTHDATE _____
Last First Middle

_____ SS# _____
Mailing Address Street

_____ Telephone _____
City State Zip

EMPLOYER _____ Work Telephone _____

eMail Address _____

Who may we thank for referring you to our office? _____

Please list family members who are patients here _____

SPOUSE'S NAME _____ S.S.# _____

Address _____
Street City State Zip

EMPLOYER _____ Telephone _____

Position _____

Address _____
Street City State Zip

PERSON RESPONSIBLE FOR PAYMENT _____

Address _____
Street City State Zip

_____ S.S.# _____

EMPLOYER NAME _____ Telephone _____

Address _____
Street City State Zip

DENTAL
INSURANCE CO. _____ Group or Policy # _____

POLICY HOLDER'S NAME _____ S.S.# _____ Birthdate _____

If not patient, give relationship to policy holder _____

ADDITIONAL INSURANCE CO. _____ Group or Policy # _____

POLICY HOLDER'S NAME _____ S.S.# _____ Birthdate _____

EMPLOYER _____ Telephone _____

Person (not living with you) to be contacted in case of emergency:

Name _____ Phone # _____

I will be paying today by: ☐ Cash ☐ Check ☐ Credit card

I understand and agree that (regardless of insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I have read all of the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct. I will notify you of any changes in health status or the above information.

_____ _____

Signature Date