PATIENT REGISTRATION

Today's Date:_____

Patient Name	Birthdate	Age	Sex ☐ M ☐ F
Home Address	City	State	Zip

Home Phone #	Please Check One ☐ Single ☐ Married ☐ Separated ☐ Widow	YOUR Social Security #
Your Employer	Occupation	Work Phone #
Are you a full time student ☐ Yes ☐ No	If patient is a minor, we need Mother & Father's Names & Birthdates	
Person responsible for account:		YOUR Driver's License Number:
Name of Spouse (or parent if minor)	YOUR E-mail Address	YOUR Cell Phone #
Spouse's (or parent's) Employer	Spouse's Social Security #	Spouse's Work Phone #

EMERGENCY INFORMATION Name, Address, & Telephone of a relative not living with you:

How did you hear about our office?

Reason for this visit?

Dental Insurance Information (Primary Carrier)			If you have dual insurance coverage, complete this for the second coverage		
Insured's Name	DOB	SS#	Insured's Name	DOB	SS#
Insured's Employer			Insured's Employer		
Insurance Company			Insurance Company		
Insurance Co. Address			Insurance Co. Address		
Phone #			Phone #		
Group #	Policy #		Group #	Policy #	

Is there anything else about your medical or dental history we should know about?

Patient Signature (or parent of child)	Date	Doctor's Signature