

Patient Registration

Today's Date _____

Patients Date of Birth _____

Patients Name _____ Name of your Spouse _____

If Patient is a Minor, Print Parents Name _____

Circle One: Single Widowed Married Divorced Separated Domestic Partner

Check here if you would like to receive email correspondences

What is your preferred email? _____

Mailing Address: _____

City _____ State _____ Zip code _____

Home Phone _____ Cell Phone _____

Patient Employed by _____ Phone _____

City _____ State _____ Zip Code _____

Present Position _____ How long held? _____

Spouse Employed by _____ Phone _____

City _____ State _____ Zip Code _____

Present Position _____ How long held? _____

Emergency Contact Information:

Who should be notified? _____

Phone _____ **Relationship to patient** _____

Do you have **Dental Insurance** that may cover part of our Professional Services: YES NO

Policy Holder Name _____ Date of Birth

Member ID or SSN _____ Group Number _____

Insurance Company _____ Name of Employer _____

Secondary Dental Insurance:

Policy Holder Name _____ Date of Birth _____

Member ID or SSN _____ Group Number _____

Insurance Company _____ Name of Employer _____