

# PATIENT REGISTRATION

Welcome and thank you for choosing our practice for your dental care. Please take a few minutes to complete this form to the best of your ability. The information you provide is essential in ensuring that you receive the best dental care possible. Any items about which you are uncertain, please leave blank and bring to our attention. We look forward to working with you in maintaining your oral health. Please complete all pages and don't forget to sign and date!

## Patient Information

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_  
Patient \_\_\_\_\_  
Last Name First Name Initial Preferred Name  
Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email Address \_\_\_\_\_  
Gender: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Occupation \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_  
In case of emergency, who should we notify? \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone Number  
If you are not receiving treatment today, what is your relationship to the patient? \_\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_

## Insurance Information

No insurance at this time

### Primary Dental Insurance

Please provide your insurance card so a copy can be made for our records

Person responsible for account \_\_\_\_\_  
Last Name First Name Initial  
Relation to Patient \_\_\_\_\_ Date of Birth \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patient's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Person responsible employed by \_\_\_\_\_  
Business Address \_\_\_\_\_  
Street City State Zip  
Business Phone (\_\_\_\_) \_\_\_\_\_ Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_

### Additional Dental Insurance

Is patient covered by any additional dental insurance?  Yes  No  
Subscriber name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Relation to patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Address (if different from patient's) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_  
Names of other dependents covered under this plan \_\_\_\_\_