Patient Registration

Today's Date:_____

PATIENT'S NAME	BIRTHDATE	AGE	SEX

ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE	SOCIAL SECURITY #	EMAIL ADDRESS

EMPLOYER-If retired from what company?	OCCUPATION	WORK #

DO YOU GO SOUTH IN THE WINTER MONTHS? IF SO WHERE AND WHAT MONTHS ARE YOU GONE?

Winter Contact #

PERSON RESPONSIBLE FOR ACCOUNT	DRIVERS LICENSE # (of parent if minor)

PLEASE CIRLCE ONE Single/Married/Divorced/Widowed/Separated	SPOUSE (or parent if minor)	SPOUSE'S DOB (or parent)

SPOUSE'S (or parent's) EMPLOYER	WORK PHONE	CELL PHONE

EMERGENCY INFORMATION— Relationship, name & telephone (different from person listed above):

How did you hear about our office?	Reason for visit?

DENTAL INSURANCE INFORMATION (Primary Carrier)			Secondary Dental Insurance		
Insured's Name	DOB	SS#	Policy Holder'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 #	

Patient Signature (or parent if child):	Date:

Parent Signature if Patient is 18 or older but still on your account:	Date: