

# PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION



DATE				<b>1</b>	
LAST NAME		FIRST		M.I.	
PREFERS TO BE CALLED BY					
ADDRESS					
CITY		STATE		ZIP	
HOME PHONE NO.			FAX		
CELL			EMAIL		
BIRTHDATE	AGE	MALE	FEMALE		
MARRIED	SINGLE	DIVORCED	WIDOWED		
SOCIAL SECURITY NO.					

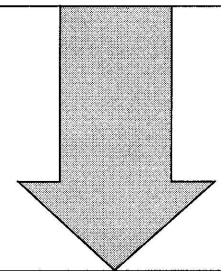
  

DATE					
LAST NAME		FIRST		M.I.	
ADDRESS					
CITY		STATE		ZIP	
HOME PHONE NO.					
BIRTHDATE	AGE	MALE	FEMALE		
SCHOOL			GRADE		
SOCIAL SECURITY NO.					

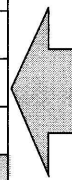


IF YOUR CHILD'S LAST NAME AND/OR ADDRESS ARE NOT THE SAME AS YOURS, FILL IN THE TOP BOX ALSO

DENTAL INSURANCE		<b>2</b>
<b>PRIMARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		
<b>SECONDARY CARRIER</b>		
INSURANCE COMPANY		
GROUP NO.		
EMPLOYER NAME		
INSURED'S NAME		
DATE OF BIRTH	RELATIONSHIP TO PATIENT	
INSURED'S I.D. NO.		
INSURED'S SOCIAL SECURITY NO.		



<b>ACCOUNT INFORMATION</b>		<b>4</b>
<b>PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT</b>		
NAME		
RELATIONSHIP TO PATIENT	SOCIAL SECURITY NO.	
ADDRESS		
CITY	STATE	ZIP
PHONE NO.		
<b>YOU</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	
<b>YOUR SPOUSE</b>		
NAME		
OCCUPATION		
EMPLOYER'S NAME		
ADDRESS	CITY	
PHONE NO.	FAX NO.	



<b>GETTING TO KNOW YOU</b>		<b>3</b>
<b>IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?</b>		
NAME:	RELATIONSHIP:	
<b>YOU WERE REFERRED TO US BY</b>		
<b>YOUR FORMER ADDRESS</b>		
CITY	STATE	ZIP
<b>PERSON TO CONTACT FOR EMERGENCY</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP
<b>CLOSEST RELATIVE NOT LIVING WITH YOU</b>		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP