

PATIENT REGISTRATION

Patient's Name _____ Birthdate _____

Name you prefer to be called _____ Email address (optional) _____

Street Address _____ Home Phone _____

City _____ State _____ Zip _____ Business Phone _____ Cell Phone _____

Marital Status: Single Widowed Married Divorced Separated

Name of Spouse _____ Spouse's Birthdate _____

In an emergency, who should be notified? _____ Phone Number _____

EMPLOYMENT

Patient's Employer _____ Address _____

Present Position _____

Social Security Number _____

Do you have **dental** coverage through this employer? _____

If yes, please provide us with the following information:

Insurance Company Name _____

Address _____

Phone Number _____ Group Number or ID Number _____

Spouse's Employer _____ Address _____

Present Position _____

Social Security Number _____ (if there is insurance coverage)

Do you have **dental** coverage through this employer? _____

If yes, please provide us with the following information:

Insurance Company Name _____

Address _____

Phone Number _____ Group Number or ID Number _____

Person responsible for this account: _____

Who may we thank for referring you to this office? _____

Your Signature: _____ **Date:** _____

Comments: _____
