REGISTRATION

(Please complete both sides of this form)

Full Name of Patient
MISS
MRS.
MR. ______________________________ (Nickname) ______ Date ______
Date of Birth ______

Residence Address ______ SS # ______

City ______ State ______ Zip ______

Residence Phone ______ Business Phone ______ Cell# ______

Email Address ______

Place of Employment ______

Employer Address ______

Whom may we thank for referring you to our office? ______

Who is responsible for this account? ______

We would like to get to know our patients. Please tell us something about yourself (e.g. Church, community activities, hobbies or interests). ______

Complete this section if dental insurance may assist in handling a portion of your account:

Name of Insurance Carrier ______ Group No. ______ ID# ______

Full Name of Employee ______ SS# ______
(If different from patient)

Employee Address ______ Birth Date: ______
(If different from patient)

Place of Employment ______

Employer Address ______

Is patient covered by another dental plan? ☐ YES ☐ NO

If so,
Name of Insurance Carrier ______ Group No. ______ ID# ______

Full Name of Employee ______ SS# ______

Employee Address ______ Birth Date: ______
(If different from patient)

Place of Employment ______

Employer Address ______

Complete this section ONLY if patient is a minor or full-time student:

School ______

Full name of Parent or Legal Guardian ______

Address ______ City ______ State ______ Zip ______

Residence Phone ______ Business Phone ______

I authorize treatment for this patient ______
Signed: (parent or legal guardian)