

# REGISTRATION

Full Name

Miss  
Mrs.

Mr. \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Nickname)

Address: \_\_\_\_\_ SS# \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_ Receive Text Messages? Y N

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). \_\_\_\_\_

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

Name of Insurance Carrier \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Full Name of Employee \_\_\_\_\_ SS# \_\_\_\_\_

Employee Address \_\_\_\_\_ Birth Date \_\_\_\_\_

Place of Employment \_\_\_\_\_

Employer Address \_\_\_\_\_

Is patient covered by another dental plan? Yes No

Name of Insurance Carrier \_\_\_\_\_ Group# \_\_\_\_\_ ID# \_\_\_\_\_

Full name of employee \_\_\_\_\_ SS# \_\_\_\_\_

Employee Address \_\_\_\_\_ Birth Date \_\_\_\_\_

Place of Employment \_\_\_\_\_

Employer Address \_\_\_\_\_

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

School \_\_\_\_\_

Full name of Parent or Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

I authorize treatment for this patient \_\_\_\_\_

Signature of parent or legal guardian