Patient Registration Information
Confidential

Welcome to our practice!

Thank you for selecting our dental healthcare team. Please fill out this form completely in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We will be happy to help!

Date_____

Patient's Name_____
First Mi Last

Address_____ City_____ State____ Zip_____

Home #_____Work #_____ Cell#_____

Email_____

Do you prefer to receive calls at: ☐ Home ☐ Work ☐ Cell

Patient's Date of Birth _____ Social Security #_____

Driver's License #_____

Are you: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If you are a student, name of school/college_____

Please provide us with the name and phone number of a contact person that we can call if we are unable to reach you to confirm your appointment.

Name of contact person_____ Phone number of contact person_____

Responsible Party: **Please circle** Self Parent Other

Responsible Party Information if other than self:

Name/Relationship_____

Address _____

Date of Birth_____ Social Security #_____ Driver's Lic#_____

Employer_____Work #_____ Home#_____Cell#_____

Is this person currently a patient in our office? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Person to contact in case of an emergency_____ Phone #_____

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