

PATIENT REGISTRATION

Date ___/___/___ Patient's Name _____ If child, parent's name _____

Single ___ Married ___ Other ___ Date of Birth _____ Age _____ Referred By: _____

Address _____ City _____ State: _____ Zip: _____

Telephone: Home _____ Work _____ Cell _____

E-Mail _____

Please confirm my appointment at ___home ___work ___cell ___e-mail

Employer _____ How long held _____

Person responsible for account: _____ Social Security # _____

Address and phone number if different from above _____

Insurance company _____ Employer _____ Group number _____

Subscriber's name _____ Date of Birth _____ ID# _____

What is the purpose of your visit? _____

How long since last dental exam or appointment? _____ Was treatment completed? _____

Name of previous dentist and location _____ Phone # _____

Date of last medical exam _____ Findings: _____

Name of present physician and location _____ Phone # _____

Name and address of nearest relative (not living at same address) _____

In case of emergency notify _____ Phone # _____.