

Patient Information and Registration

Patient's Name: _____ Date: _____

Gender: _____ Birthday: _____ Social Security #: _____

Street Address _____

City: _____ State: _____ Zip Code: _____

How long have you been at this address? _____

E-Mail Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred number for contact _____

Employer Name: _____ Occupation: _____

Are you responsible for this account? **Yes No** If no, please provide the following information for the responsible person:

Name: _____ Relationship to you: _____

Address: _____

Birthday: _____ Social Security #: _____

E-Mail Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Occupation: _____

Dental Insurance Information

Insured's Name: _____ Insured's Social Security #: _____

Insured's Birthday: _____ Insured's Employer: _____

Insurance Company Name: _____ Group # _____

Insurance Company Address: _____

Emergency Contact Information

Name: _____ Relationship to you: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How did you find out about our office? (Please circle all that apply): Magazine, Website, Personal referral.

If referral, please let us know who to thank! _____

Please mail forms to our office three days before your visit, or bring with you 10 minutes prior to your first appointment.

We look forward to serving you!