PATIENT REGISTRATION

WELCOME!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental needs, please fill out these forms completely. If you have any questions or need assistance, please ask us—we will be happy to help you.

PATIENT INFORMATION (CONFIDENTIAL) Date ________________

Name (First) __________________________ (Last) ___________________________ (Middle) ___________

Address (Mailing) ____________________________________ City _____________ State _____ Zip _______

(Physical)____________________________________ City _____________ State _____ Zip _______

Home Phone (_____)____________ Cell Phone (_____)______________ DOB ______________

Sex: Male or Female E-mail Address____

Please list the contact number at which we may confirm your appointments ________________________

Please Check Appropriate Response: Minor ___ Single ___ Married ___ Divorced ___ Widowed ___

Patient's Employer ____ Work Phone __________________

Employer's Address __________________________________ City _____________ State _____ Zip ______

Spouse's Name _______________________ Spouse's Phone (_____)_____________________

Contact in Case of Emergency _________________________________ Phone (_____)__________________

Relationship to Patient ___________________________

Whom May We Thank for Referring You to Our Office? ____

Dental Insurance: Yes or No If yes, please have your card ready.

Chief Concern for today's visit____

If the patient is a minor (less than 18 years old), please complete the following information:

Name of Patient's Guardian(s) ____

Address: ________________________________ City ______________ State ______ Zipcode _______

Home Phone __________________________ Cell Phone _________________________