PATIENT REGISTRATION

PATIENT INFORMATION

Patient's Name________________________________**Phone No**. (___)___________________ (circle one) Single Married Separated Divorced Widowed

Street Address________________________________**City/State/Zip**_______________________

Social Security No.__________________________**Date of Birth**__________________________

Drivers License No.____________________________

Patient's Employer/Address___________________________________**City/State/Zip**___________________________

Present Position_________________________**How Long Held**_____________**Phone No.**(___)________________

SPOUSE'S INFORMATION

Spouse's Name______________________________________**Drivers License No.**______________________________

Social Security No.____________________________**Date of Birth**_______________________________________

Spouse's Employer__________________________________**Phone No.** (___)___________________________________

Employer Address______________________________________**City/State/Zip**_____________________________

PRIMARY DENTAL INSURANCE INFORMATION

Dental Insurance Company__________________________________**Group No.**________________________________

Name of Employee_____________________________________**City/State/Zip**_____________________________

Social Security No.__________________________________**Date of Birth**_________________________________

Name of Employer___________________________**Phone No.**(___)__________**City/Zip**____________________

SECONDARY DENTAL INSURANCE INFORMATION

Dental Insurance Company________________________________**Group No.**__________________________________

Name of Employee_____________________________________**City/State/Zip**_____________________________

Social Security No.___________________________________**Date of Birth**________________________________

Name of Employer___________________________**Phone No.**(___)_____________**City/Zip**___________________

In Case of Emergency, Who should be notified outside of the home?______________________________________

Address_________________________________City/State/Zip____
Phone No. (___)________________

Whom May We Thank for Referring You?____

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I understand that I am fully liable for any outstanding charges not covered by my insurance company, and that payment is due at the time services are rendered unless prior arrangements have been made.

Signature of Patient or Parent____Date____________________________