Patient Registration

Welcome and thank you for selecting our office to serve your dental needs!
We're committed to offering our patients high quality & convenient dental care. In order to allow us to best meet your needs please fill out the information carefully.

Name: ____

Date of Birth: ______________________________

Nickname: ____

Social Security #: ___________________________

Address: ____

City, State, Zip: ____

Home Phone #: ____

Work Phone #: ____

Gender
( ) Male
( ) Female

Marital Status
( ) Single
( ) Married
( ) Divorced
( ) Widowed

Cell Phone #: ____

Employer: _________________________________

Email Address: ____

Occupation: _______________________________

What is your preferred method of contact? ( ) PHONE ( ) TEXT ( ) EMAIL *check all that apply*
What is the best time of day to reach you? ( ) MORNINGS ( ) AFTERNOONS ( ) EVENINGS after _____ P.M.
Where do you prefer to receive calls? ( ) HOME ( ) WORK ( ) CELL *check all that apply*
Do you have a fixed or flexible work schedule? ( ) FIXED ( ) FLEXIBLE
If we have an opportunity to see you sooner than your reserved time, would you like us to let you know? ( ) YES ( ) NO

Who may we thank for referring you to our office, or how did you hear about us? ____________________________________

Emergency Contact Name & Phone #: ____

Name of Primary Care Physician & Phone #: ____

Dental Insurance Information

Policy Holder Name: ____

Date of Birth: ______________________________

Employer: ____

Insurance Co: ______________________________

Claims Address: ____

SS/ID #: __________________________________

Relation to Patient: ( ) Self ( ) Spouse ( ) Parent ( ) Other

Group #: __________________________________

Responsible Financial Party

Name: ____

Relationship to Patient: ___________________

Social Security #: ____

Date of Birth: ______________________________

Driver's License #: ____

State of Issue: ______________________________

I consent to and authorize any face, profile, head/neck &/or inside the mouth photographs, video or other image that may be necessary of me/my child, with or without my given name or with a fictitious name, for treatment, education and any other lawful healthcare or identification purposes. I release and forever discharge these photos from any claim of ownership, demands or liability on account for such use and acknowledge they are the exclusive property and copyright of my dentist.

Signature: ____

Date: ______________________________________