PATIENT REGISTRATION

Last Name:	First:		Middle Initial:
Street Address:			Apartment/Unit #:
City:	State:	ZIP:	Birth Date:
Home Phone: ( )	Cell Phone: ( )		
Work Phone: ( )	Ext:		
Social Security No:		Driver's License:	
Male ☐ Female ☐	E-Mail Address:		
Student Status:	Full Time ☐ Part Time ☐	Emergency Contact:	
Referred By:		Emergency Contact Phone: ( )	
Date of Last Dental Visit:		Date Of Last Cleaning:	
Name of Last Dentist:		Office Phone: ( )	
Address:		Any Concerns About Your Teeth?	
City/State/Zip:			

PERSON FINANCIALLY RESPONSIBLE FOR THIS PATIENT (IF OTHER THAN PATIENT)

Last Name:	First:		Middle Initial:
Street Address:			Apartment/Unit #:
City	State:	ZIP:	Birth Date:
Home Phone: ( )	Cell Phone: ( )		
Work Phone: : ( )	Ext:		
Social Security No.:	Driver's License:		
Relationship to Patient:	Parent ☐ Guardian ☐		

INSURANCE INFORMATION

Last Name:	First:		Middle Initial:
Subscriber's Birth Date:	Subscriber's ID:		
Employer:		Group Number:	
Insurance Company:			
Address:			
City:	State:	ZIP:	Phone: ( )
Relationship to Patient:	Self ☐ Spouse ☐ Child ☐ Other ☐	Do You Have Secondary Insurance?	Yes ☐ No ☐

SIGNATURE OF PATIENT OR LEGAL PARENT/GUARDIAN

Signature :	Date :