REGISTRATION

Information is confidential, and important. Accurate answers are necessary for such matters and proper diagnosis, protection of your and our general health, efficiency, and optimum dental treatment. We welcome you as a patient and look forward to taking care of your dental needs.

Date: _____

Circle One: Mr. Mrs. Miss Ms. Dr.

Patient Name: _____
(Last) (First) (Middle)

Date of Birth : _____ **Male**_____ **Female**_____ **Preferred Name:** _____

Cell Phone: _____ **Home Phone:** _____

Email Address: _____

Home Address: _____
(Address – City – State – Zip)

Single _____ **Married** _____ **Spouse's Name:** _____
(or parents name if child)

Occupation(s): _____ **Employer:**_____

Reason for selecting our office: _____

Emergency Contact: _____**Phone Number:** _____
(Name)

Person(s) responsible for this account: _____
(To whom statement should be sent): _____
(Address – City - State – Zip) (Phone)

Dental Insurance Company: _____ **Employer:** _____

Policy Holder: _____ **Policy Holder DOB:** _____

Policy ID #: _____**Group #:** _____

SIGNATURE _____