

**PATIENT INFORMATION (CONFIDENTIAL)**Name \_\_\_\_\_ Date \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-Mail \_\_\_\_\_

Wk # \_\_\_\_\_ Hm # \_\_\_\_\_ Cell # \_\_\_\_\_ Birthdate \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Divorced  Widowed  Separated

Spouse/Guardian Name \_\_\_\_\_

If College Student, FT / PT, Name of School \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of an emergency \_\_\_\_\_ phone \_\_\_\_\_

**RESPONSIBLE PARTY** – (Responsible for paying account)

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Driver's License \_\_\_\_\_ Birthdate \_\_\_\_\_

Is this person currently a patient in our office?  Yes  No**DENTAL INSURANCE INFORMATION**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# / ID# \_\_\_\_\_

Employer \_\_\_\_\_ wk # \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_ Grp # \_\_\_\_\_

Ins Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**DO YOU HAVE ADDITIONAL DENTAL INSURANCE?**  YES  NO **IF YES, COMPLETE THE FOLLOWING:**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# / ID# \_\_\_\_\_

Employer \_\_\_\_\_ wk # \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Phone \_\_\_\_\_ Grp # \_\_\_\_\_

Ins Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**REGISTRATION**