PATIENT REGISTRATION

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Section I

PATIENT INFORMATION

First Name: ____________ Last Name: ____________ Middle Initial: ______
Address: ____________ City: ____________ State: ______ Zip Code: ______
Home Phone: ____________ Work Phone: ____________ X______ Cellular: ____________
Sex: O Male O Female Marital Status: O Single O Divorced O Separated O Married
Birth Date: ____________ Age: ______ Social Security Number: ______-______-______ Driver Lic. ____________
E-Mail: ____________ □ I would like to receive correspondences via e-mail
Student Status: O Full Time O Part Time
Type of Dental Insurance: O Private: ____________ O Medicaid: #____________ O Other: ______

Section II

PARENT / GUARDIAN INFORMATION

O Primary Ins. O Secondary Ins.

MOTHER / STEP-MOTHER

First Name: ____________ MI ______
Last Name: ____________
Date of Birth: ____________ Age ______
Marital Status: O Single O Married O Divorced
Social Security Number: ____________
Drivers Lic.: ____________
Address: ____________ Apt ______
City, State, Zip Code: ____________
Home Phone: ____________
Work Phone: ____________ X______
Cellular: ____________
e-mail ____________
Employer: ____________
Employer's Address: ____________
Insurance Company: ____________
Customer Services # for Ins. ____________
Group and/or ID Number: ____________

O Primary Ins. O Secondary Ins.

FATHER / STEP-FATHER

First Name: ____________ MI ______
Last Name: ____________
Date of Birth: ____________ Age ______
Marital Status: O Single O Married O Divorced
Social Security Number: ____________
Drivers Lic.: ____________
Address: ____________ Apt ______
City, State, Zip Code: ____________
Home Phone: ____________
Work Phone: ____________ X______
Cellular: ____________
e-mail ____________
Employer: ____________
Employer's Address: ____________
Insurance Company: ____________
Customer Services # for Ins. ____________
Group and/or ID Number: ____________

Section III

DOCTOR/PEDIATRICIAN ____________ ADDRESS/PHONE ____________

How did you hear about us?: PREVIOUS DENTIST: ____________
O Window Sign O Street sign O Flyer Doctor Referral ____________
O Family / Friend ____________ **O Other** ____________

EMERGENCY CONTACT: ____________ **EMERGENCY CONTACT NUMBER:** _(_____)____________

MEDICAL HISTORY IN THE NEXT PAGE...

PLEASE PROVIDE US WITH ALL THE INFORMATION SO WE CAN SERVE YOU BETTER.
NOTE THAT THIS INFORMATION IS CONFIDENTIAL AND WILL NOT BE GIVEN OUT TO THIRD PARTIES UNLESS YOU SIGN A RELEASE FORM.

FOR INSURANCE PATIENTS: I AM AWARE THAT MY INFORMATION HAS TO BE USED TO CHECK ELIGIBILITY OF MY CURRENT DENTAL INSURANCE, IF I DON'T WANT TO GIVE ANY INFORMATION I AGREE TO PAY FOR SERVICES IN FULL.