Date ___________

Patient Registration

Patient Information: ***required for accepting checks and filing insurance***

*First Name _______________ Last Name___________________ Preferred Name___________

*Address:_______________________________ City_______________ State____ Zip________

*Home Phone______________________ Work Phone______________________ Ext________

Cell____________________ Yes, you may send appointment reminders via text message _____

Emergency Contact Name_______________________________ Ph#______________________

Email____________________________________ Yes, I would like email correspondences____

*Birth Date_____________ SS#___________________ DL#___________________ State_____

Sex: M______ F______ Marital Status: Married Divorced Separated Widowed

*Employer____

Pharmacy____ Ph # ____________________

I have been told that I need antibiotic premedication before dental appointments: yes no

Please let us know how you heard about our office:

Family or friend (please include name): _______________________________________

Online: Banner Ad Google MSN Live Search Yahoo Internet Yellow Pages

Other: ____

Dental Insurance Information

*Name of Insured:____

*Relationship to Patient: Self Spouse Child Other

*Employer____ Ph #_____________________

*Address____ Zip________________

*Ins Company__________________________ Ph#_________________ Group#_____________

Responsible Party (if other than patient)

Name_____________________________________ Ph #_________________DOB__________

Wk Ph#_____________________ Cell_____________________ SS#_____________________

Address____________________________ City________________ State______ Zip_________