Patient Registration

Date: _____

Patient Information

Patient's Name: _____

☐ M ☐ F Birthdate: _____ SS#: _____

☐ ☐Married ☐ ☐Single ☐ Divorced ☐ ☐Minor E-mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #(_____)_____ Cell #(_____)_____ Work #(_____)_____

Who can we thank for your referral?: _____

HAVE YOU TRAVELED LATELY? YES / NO WHERE_____

IN CASE OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name: _____ Relation: _____

Home #: (_____) _____ Other #: (_____) _____

Responsible Party (For Minors Only)

Name: _____ Relation: _____

☐ M ☐ F Birthdate: _____ SS#: _____

Home #(_____)_____ Cell #(_____)_____ Work #(_____)_____

Employer: _____ Occupation: _____

Insurance Information

Insurance Co. Name: _____ Phone #: (_____)_____

Address: _____

ID #: _____ Group #: _____

Policy Owner's Name: _____ Relation: _____

Birthdate: _____ SS#: _____

THE X-RAYS OF THE PATIENT'S TEETH ARE PROPERTY OF THIS OFFICE BY LAW. AN ADDITIONAL CHARGE WILL BE REQUIRED FOR ANY COPY YOU MAY NEED.

_____ _____

Signature of Patient/Responsible Party Date