Patient Registration

Welcome! Please complete the following confidential information to help us serve you better.

Patient Infomation:

Patient : _____
Address: _____
City/State/Zip: _____
Telephone(Home)_____(Work)_____(Cell)_____
Employer/School: _____
Date of Birth: _____ Social Security Number_____-____-_____

Do you have dental insurance? ☐ Yes / ☐ No (*If yes, proceed to the next box. If no, skip the next box.*)

Dental Insurance Information:
Is the dental insurance in your name? ☐ Yes / ☐ No

If yes, Insurance Company _____
ID#_____ Group#_____

If no, Insured's Name_____Date of Birth _____
Employer _____
Insurance Company _____
ID#_____ Group#_____

Secondary Coverage?
If yes, Insured's Name_____Date of Birth _____
Employer _____
Insurance Company _____

Account Information:
(If different than the patient, please complete)
Send Bill To:
Name: _____
Address: _____City/State/Zip: _____
Telephone(Home)_____(Work)_____(Cell)_____
Employer/School: _____
Social Security Number_____-____-_____ Employer _____

In case of emergency, whom should we contact?_____Telephone_____
Relationship_____

Referred to us by: _____