

PATIENT REGISTRATION

Name: _____

Home Address: _____
Street City

State Zip How Long? _____

E-mail: _____

Home Ph: _____ Work Ph: _____

Birthday: _____ Age: _____ Single _____ Married _____ Div. _____ Sep. _____ Widowed _____

Social Security No.: _____ Driver's License No.: _____

Your Employer: _____ Occupation: _____ Years with firm: _____

Employer's Address: _____
Street City

Spouse's Name: _____

Spouse's Employer: _____ Occupation: _____ Years with firm: _____

Employer's Address: _____
Street City Telephone: _____ Ext.: _____

Nearest Relative _____ Home Tel: _____
Not Living with You Name

Street City Zip Work Tel: _____

Physician: _____ Telephone: _____ Last Physical: _____
Name City

Previous Dentist: _____ Years: _____
Name City

Referred By: _____

Person responsible for this account: _____ Relationship: _____

Address: _____
Street City State Zip

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest, charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information on these forms has been completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____