PATIENT REGISTRATION FORM

Today's Date_________________ Birth Date_____________

Name____ M / F Preferred Name_____________________
Last First Middle

Social Security # ___________________________ ___Married ___Single ___Divorced ___Separated___ Widowed

Address ____
Street or PO Box # City State Zip

Home Phone ______________________ Cell Phone ______________________ Work Phone ______________________

Email Address ____ Can we email you? _____Yes _____No

Person Responsible for This Account _________________________________ Relationship to PT ___________________

Patient Place of Employment/Retired ___________________________ ______________________ ______________
Position City

Spouse Employment/Retired __________________________________ ______________________ ______________
Position City

Emergency Contact Person Name ____ Phone: __________________

Who May We Thank for Referring You? ____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. ____ Group # __________________________

Subscriber __________________________ Birth Date ___________________ SS#/ID# ____________________________

Address if Different from Patients ____

Employer or Group Name ____ Phone __________________

Secondary Insurance Co. ____ Group # ____________________________

Subscriber _________________________ Birth Date ___________________ SS#/ID# _________________________________

Address if Different from Patients ____

Employer or Group Name ____ Phone ___________________

HEALTH HISTORY

Personal Physician ___________________________________ Phone _____________________ City ________________

Current Health: ___Excellent ___Good ___ Fair ___Poor ___Being Treated For __________________________________

Past or Current Serious Illnesses ____

Currently Pregnant Y / N Use Tobacco in Any Form Y / N Excessive Bleeding From Cuts or Extractions Y / N