



Welcome Patient Registration

PATIENT NAME (Last, First, Middle Initial)	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP	MARITAL STATUS
HOME PHONE: _____ CELL PHONE: _____	Gender: Male Female
NAME OF EMPLOYER:	RELATIONSHIP TO INSURED Self Spouse Child
EMPLOYER ADDRESS:	WORK PHONE
EMPLOYER PHONE NUMBER:	EMAIL ADDRESS (Please write N/A if no email address)
Who can we thank for referring you to our office? (circle all that apply) <i>Patient</i> <i>Friend</i> <i>Family Member</i> <i>Ins Plan</i> <i>Other</i>	
Name: _____	Phone No. _____

Who should be notified locally in case of emergency?

NAME	PHONE
ADDRESS	

Insurance Information

Primary Coverage

Secondary

Coverage

SUBSCRIBER'S NAME	SUBSCRIBER'S NAME	
DATE OF BIRTH	DATE OF BIRTH	
INSURANCE COMPANY	INSURANCE COMPANY	
SOCIAL SECURITY #	SOCIAL SECURITY #	
GROUP NUMBER	GROUP NUMBER	
LOCAL NUMBER OR POLICY NUMBER	LOCAL NUMBER OR POLICY NUMBER	
EMPLOYER	EMPLOYER	
OCCUPATION	OCCUPATION	
SIGNATURE _____	DATE	_____

Acknowledgement of Receipt of Notice of Privacy Practices & Dental Materials Fact Sheet

I acknowledge that I have read and/or received a copy of these documents.

Signature _____ Date _____