PATIENT REGISTRATION

ALL INFORMATION IS CONFIDENTIAL

WELCOME TO OUR OFFICE

The following information is required by the dentist to assist in proper diagnosis and treatment.
Please feel free to ask an office member for help in completing this form. PLEASE PRINT.

PATIENT REGISTRATION Dr. ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss ☐

Name: _____
(last) (first) (initial)

Address: _____
(street) (city) (prov./state) (postal/zip code)

Date of Birth: _____ Age___ Sex __ Marital Status___ Home Phone: ( )
M D Y

Height: _____ Weight: _____

Cell: _____

Email: _____

Family Physician: _____ Phone: ( )_____

Medical Specialist: _____ Phone: ( )_____

PERSON RESPONSIBLE FOR PATIENT: self ☐ parent ☐ other _____

Your occupation: _____

Employed by: _____ Phone: ( )_____ Ext._____

Spouse employed by: _____ Phone: ( )_____ Ext._____

Dental Insurance: Yes ☐ No ☐ Group Policy No.: _____ Cert. No.: _____

Insurance Co. Name _____

Secondary Insurance _____ Group Policy No.: _____ Cert. No: _____

In case of emergency , please notify: _____

Relationship: _____ Phone: ( )_____

Closest family relative _____ Phone: ( )_____

Whom may we thank for referring you? _____

Is any other relative a patient at our office? _____

Is there a dental problem you would like to have taken care of as soon as possible? _____

_____

_____

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