Patient Registration

Date: _____

Patient's Name: Last _____ First _____ MI _____
Nick Name: _____ Birth Date: _____ M / F

Home Address: _____Phone: _____
City: _____ State: ____ Zip Code: _____
Cell Phone: _____Would you prefer a text: Yes or No
If yes, what is your cell phone company: _____
Email: _____
Does your email show up on your cell phone: Yes or No
Best place to reach me:_____

Occupation: _____Employed By: _____
Business Phone: _____Social Security#:_____

Single _____ Married _____ Widowed _____ Divorced _____
Spouse's Name: _____ Employer: _____
Spouse's Business Phone: _____ Cell Phone: _____
Do you wish to have your account separate from spouse: YES or NO

Physician's Name: _____ Phone: _____
Former Dentist Name: _____ Phone: _____
Last Dental Visit Date: _____
Nearest Relative's Name (*not living with you*): _____
Phone: _____
Relationship To Patient: _____
In Case Of Emergency Notify: _____Phone: _____

Referred To Our Office By: _____

Parent's Name (if minor): _____

Person Responsible For Account: _____
Address (*If Different From Above*): _____
City, State, Zip Code: _____
Home Phone: _____ Business Phone: _____