PATIENT REGISTRATION FORM
CONFIDENTIAL INFORMATION

Patient's Legal Name

Last	*First*	*Middle*

Name You Prefer to Be Called	Sex	Date of Birth *mm/dd/yyyy*	Social Security #

Address *Street*	*City*	*State*	*Zip Code*

Home Phone #	Cell Phone #	Email

Marital Status	Patient / Guardian's Employer	Occupation
☐ **S** ☐ **M** ☐ **D** ☐ **W**		

Employer's Address *Street*	*City*	*State*	*Zip Code*	Work Phone #

Emergency Contact Name & Relationship	**Phone #**

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERSMISSION
Check All That Apply:

Yes:
- ☐ Contact me at home
- ☐ Leave messages on my home ansering machine/voicemail
- ☐ Contact me via cell phone
- ☐ Send appointment reminders via text message
- ☐ Contact me via email

Would you like a confirmation call?
☐ Yes ☐ No

Would you like a confirmation text message?
SMS rates may apply
☐ Yes ☐ No

Insurance & Financial Information

Insurance Coverage ☐ Yes ☐ No	Insurance Company Name	Address	
Subscriber Name	Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependant	Subscriber's Birthday	Subscriber's SSN / ID #
Secondary Coverage	Insurance Company Name	Address	
Subscriber Name	Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependant	Subscriber's Birthday	Subscriber's SSN / ID #