Patient Name .....

Patient Account No:.....

PATIENT REGISTRATION FORM

Medical Alert

Please complete the following confidential information. Date.....

ABOUT YOU

Name.....
Address.....
City.....State.....Zip.....
Home Phone #.....
Birth date.....Age..... ☐ Male ☐ Female
Social Security#.....
Driver's Lic.#.....
☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Spouse

ABOUT YOUR CHILD (If appointment is for your child)

Date.....
Name (Last name too if different from yours).....
Address.....
City.....State.....Zip.....
Home Phone#.....
Birth date.....Age..... ☐ Male ☐ Female
School.....Grade.....

ABOUT DENTAL INSURANCE

Primary Carrier.....
Insurance Company .....
Employee .....
Union/Local# ..... Emp. Badge#.....
Group # .....
Date Employed .....Effective Date.....
Social Security#.....
Birth date.....Age.....

Secondary Carrier.....
Insurance Company.....
Employee.....
Union/Local#..... Emp. Badge#.....
Group#.....
Date Employed..... Effective Date.....
Social Security#.....
Birth date.....Age.....

ABOUT YOUR FAMILY

Family members or Relatives who are already our patient(s).....
.....
.....

ABOUT YOUR EMPLOYER

Employer Name .....
Business Address .....
City .....

Referred to us by .....
Person to contact for emergency.....
Phone# .....
Address.....
City .....
State .....Zip .....

Business Phone# ..... Ext.....
Occupation of Spouse.....
Employer of Spouse.....
Business Address .....
City.....
Business Phone# ..... Ext.....

IF YOU NEED MORE ROOM, CONTINUE ON THE OTHER SIDE OF THE PAPER.