



**Welcome to our office!** It is our policy to use the highest quality and most appropriate dental restorative materials. We will use tooth colored materials in all cases unless it is not appropriate or you ask if an alternative is possible.

**PATIENT INFORMATION**

NAME: \_\_\_\_\_

How do you wish to be addressed? \_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Single  Married  Divorced  Widowed  Minor

**Home Address**

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone/Pager: \_\_\_\_\_

Someone not living with you in case of emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

Email \_\_\_\_\_

Best time to contact you \_\_\_\_\_

**Employment**

Employer: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Spouse/Parent**

Name: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Employer: \_\_\_\_\_ Present position: \_\_\_\_\_ How long held? \_\_\_\_\_

**ACCOUNT INFORMATION**

Person responsible for your account: \_\_\_\_\_

Method of payment: Cash VISA/Mastercard Discover American Express Care Credit

In conjunction with dental insurance? YES / NO

Would you like information on low or no interest financing plans? YES / NO

Primary Insurance		Secondary Insurance (if it applies)
<b>Insurance Company</b>	Name	
	Address	
	Phone Number	
	Policy or Group Number	
<b>Policy Holder</b>	Name	
	Date of birth	
	Social Security Number	
	Employer	

Were you referred to our office? YES Whom may we thank for this referral? \_\_\_\_\_

NO How did you hear of our office? \_\_\_\_\_

Other family members seen in this office: \_\_\_\_\_

Purpose of your initial visit here: \_\_\_\_\_

**Release: I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I attest to the accuracy of the information on this page.**

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

--	--	--	--	--	--

PATIENT NUMBER

**REGISTRATION**