

REGISTRATION FORM

SECTION 1 PATIENT INFORMATION

DATE

LAST NAME	FIRST	M.I.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER			
ADDRESS	APT #	CITY	STATE	ZIP	BIRTHDATE		
PLACE OF EMPLOYMENT (OR SCHOOL)		GRADE	HOME PHONE	OFFICE PHONE	HAS ANY MEMBER OF YOUR FAMILY EVER BEEN TREATED IN OUR OFFICES? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 2 DENTAL INSURANCE COVERAGE(S)

INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE						
EMPLOYER	GROUP NUMBER							
SUBSCRIBER LAST NAME	FIRST	M.I.	RELATIONSHIP TO PATIENT					
BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER	HOME PHONE	OFFICE PHONE	SELF <input type="checkbox"/>	SPOUSE <input type="checkbox"/>	PARENT <input type="checkbox"/>	GUARDIAN <input type="checkbox"/>

SECONDARY INSURANCE (IF APPLICABLE)

INSURANCE COMPANY	POLICY NUMBER	EFFECTIVE DATE						
EMPLOYER	GROUP NUMBER							
SUBSCRIBER LAST NAME	FIRST	M.I.	RELATIONSHIP TO PATIENT					
BIRTHDATE	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER	HOME PHONE	OFFICE PHONE	SELF <input type="checkbox"/>	SPOUSE <input type="checkbox"/>	PARENT <input type="checkbox"/>	GUARDIAN <input type="checkbox"/>

SECTION 3 ACCOUNT RESPONSIBLE PARTY

LAST NAME	FIRST	M.I.	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	SOCIAL SECURITY NUMBER			
ADDRESS	APT #	CITY	STATE	ZIP	BIRTHDATE		
RELATIONSHIP TO PATIENT							
SELF <input type="checkbox"/>	SPOUSE <input type="checkbox"/>	PARENT <input type="checkbox"/>	GUARDIAN <input type="checkbox"/>	OTHER <input type="checkbox"/>	(EXPLAIN)		
PLACE OF EMPLOYMENT (OR SCHOOL)				OFFICE PHONE	HOME PHONE		
PERSON TO CONTACT IN CASE OF EMERGENCY				OFFICE PHONE	HOME PHONE		

AUTHORIZATION

I ACCEPT THE FINANCIAL RESPONSIBILITY OF THIS ACCOUNT. THE INFORMATION ON THIS PAGE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

ACCOUNT RESPONSIBLE PARTY

DATE